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## INFORMED CONSENT FOR SERVICES

I \_\_\_\_\_, understand that only the physicians and physician assistants at the Raby Institute for Integrative Medicine at Northwestern (“Raby Institute”) are practicing medicine and prescribing any type of pharmaceuticals. I recognized that all non-physician providers are facilitating my health and well-being within the scope of their training and any licenses, and do not diagnose illness with the exception of licensed psychotherapists evaluating and diagnosing psychological conditions as needed and allowed. I also understand that for any procedures that may involve needles, Raby Institute will utilize sterilized, single-use, disposable needles.

It has been made clear to me that non-physician services are not a substitute for medical examination, nor are non-psychotherapist services a substitute for a psychological exam. I understand that it is recommended that I see a physician or psychotherapist (either at the Raby Institute or an outside provider) should those services be required or advised.

I take responsibility for keeping the Raby Institute apprised as to my state of health and all known medical conditions. I know that I am encouraged to discuss any question or concerns with my provider(s).

I authorize the Raby Institute to charge my credit card \$100 (for existing patient) or my providers full fee (for new patient) if I cancel/reschedule my appointment with less than 24 hours, or if I fail to present at my appointment.

I have read the above, and voluntarily consent to the treatment and education at the Raby Institute.

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\_\_\_\_\_  
Patient Signature (or legal guardian, if patient is a minor)

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\_\_\_\_\_  
Date

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### Authorization to Release Information

I, \_\_\_\_\_, hereby authorize the Raby Institute to release relevant personal medical history at any time, and that any changes to this authorization must be made in writing and delivered to the Raby Institute for Integrative Medicine, 500 N. Michigan Avenue, Suite 450 Chicago, IL 60611

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\_\_\_\_\_  
Patient Signature (or legal guardian, if patient is a minor)

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\_\_\_\_\_  
Date