Highlands Integrative Pediatrics

Osteopathic Treatment Informed Consent

Your child will be evaluated and treated by Dr. Erin Woessner, D.O. a licensed, board-certified osteopathic physician here at Highlands Integrative Pediatrics. Healthcare services offered may include but are not limited to Crystalline Consciousness Technique™, dry needling, essential oils, homeopathic remedies, Light-Life Technology®, nutritional supplements, osteopathic manipulation treatments and pranic healing. These services are not intended to replace other primary care your child is receiving, nor should your child discontinue any treatments or medications prescribed or recommended by your primary care physician.

You acknowledge, consent, and hereby authorize Dr. Woessner to carry out your child's healthcare treatment.

You acknowledge, consent, and hereby authorize Dr. Woessner to carry out alternative medicine, modalities, techniques, and treatments for your child. Dr. Woessner and Highlands Integrative Pediatrics make no claims, representations, or warranties as to the risks or benefits of alternative medicine. If you have any questions about alternative medicine, ask Dr. Woessner prior to receiving services.

You acknowledge and understand that this consent is given in advance of any specific diagnosis or treatment, that these services for your child are received voluntarily, and that you have the right to refuse these Services. You understand and intend this consent to be continuing in nature, even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force and effect unless revoked in writing and will not affect any actions that were taken prior to receiving your revocation.

Fees: If your child has health insurance and Highlands Integrative Pediatrics is in-network with your plan, a claim will be submitted to your insurance company for services rendered.

If your child is uninsured, you acknowledge the current self-pay fee you are responsible for is $360 for a new patient visit and $210 for each follow up visit. These fees will be collected at the time of service.

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Signature of parent or legal guardian (if patient is under 18 years old) Date

Name of person entering into this Agreement:
Relationship to patient:

Patient Name:_____

Date of Birth:_____/_____/_____