JonathanDudley
HOLISTIC HEALTHCARE

GENERAL CONSENT FOR HOLISTIC TREATMENT

I have sought the health care services of Jonathan Dudley for my personal healthcare or for my child(ren) who are minors. I understand that this medical practice uses some treatment methods that are known as complementary, alternative, or holistic. These terms refer to therapies that include dietary and nutritional supplement advice, homeopathy, Morphogenic Field Technique™ and Neuro Emotional Technique®. Approaches for improving health may be based upon the evaluations and philosophies of complementary medicine and may or may not be consistent with mainstream medical evaluations and philosophies. I understand that Jonathan Dudley is not licensed by the State of California.

I understand that all information disclosed during the consultation is confidential and may not be revealed to anyone without my consent, except where disclosure is required by law. However, I authorize discussion of my case notes with other complementary therapists if my best interests be served by such a consultation. My right to privacy will be protected by withholding my name and any other identifying information.

Please place a ✓ and/or a ✘ against the appropriate therapy / therapies:

☐ MORPHOGENIC FIELD TECHNIQUE™: I specifically authorize Jonathan Dudley to use a Morphogenic Field Technique™ health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease. I understand that Morphogenic Field Technique are safe, non-invasive, natural methods of analyzing the body's physical needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems. I understand that they are not methods for "diagnosing" or "treating" any disease including conditions of cancer, infections, or other medical conditions, and that these are not being tested for or treated. It is therefore strongly recommended that in addition to holistic care, I maintain a relationship with one or more physicians qualified to care for my health condition(s). No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional or dietary programs recommended, but rather I understand that it is a means by which the body's natural responses can be used as an aid to determining possible imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health. I understand that I am to adhere to the program guidelines. These guidelines have been fully laid before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success. I also consent to the appropriate body contact required for this and other kinesiological muscle testing treatments. This permission form applies to subsequent visits and consultations.

☐ NEURO EMOTIONAL TECHNIQUE®: I understand that Neuro Emotional Technique is a procedure that concerns my "emotional reality" and that this does not necessarily correlate to actual events. I also consent to the appropriate body contact required for this and other kinesiological muscle testing treatments and, where appropriate, I agree that any remote/online NET consultations are conducted with my full agreement and consent.

I am over 18 years of age and understand this consent agreement and have executed it freely and willingly. My signature verifies that I have not been told to discontinue treatments or medications with any other medical specialists or health care providers, and that any such changes to prescriptions and/or dosages must be made only upon agreement with the prescribing physician.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

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