ARIZONA NATURAL FAMILY MEDICINE – MARIO HOWELL M.Ed., N.D.

INFORMED CONSENT

I hereby permit Arizona Natural Family Medicine and Dr. Mario Howell, or his/her Associate Attending Physician of the same service, and assistants as may be selected and supervised by him/her to perform the following medical treatment, procedure or operation (hereafter the "procedure"):

- Prolotherapy
- IM Administration
- Nutritional Consultation
- Botanical Medicine
- Pharmaceutical Interventions
- Hormonal Therapy
- Medical Marijuana Certification

The procedure has been explained to me and I have been told the reasons why I need the procedure. The risks of the procedure have also been explained to me. In addition, I have been told that the procedure may not have the result that I expect. I have also been told about other possible treatments for my condition and what might happen if no treatment is received.

I understand that in addition to the risks described to me about this procedure there are risks that may occur with any surgical or medical procedure. I am aware that the practice of medicine and surgery is not an exact science, and that I have not been given any guarantees about the results of this procedure.

I have had enough time to discuss my condition and treatment with my health care providers and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision and I agree to have the procedure.

If something unexpected happens and I need additional or different treatment(s) from the treatment I expect, I agree to accept any treatment that is necessary.

X _____ _____

Signature of Patient **Date**

WITNESS:

I, _____ am a facility employee who is not the patient's physician or authorized health care provider named above and I have witnessed the patient or other appropriate person voluntarily sign this form.

X _____ _____

Signature of Staff Member **Date**