WILDEDETOX
wildedetox.com | Dr. Sarah P. Wilde, GPC, AP

CLIENT INFORMED CONSENT-DISCLAIMER-WAIVER-FINANCIAL RESPONSIBILITY

I have undergone a standard, conventional medical diagnostic workup and have been made aware of my diagnosis and/or health condition(s). If the diagnosis is cancer, I have consulted with an oncologist and I have been advised of the standard, recommended approach to treatment for my condition.

Of my own volition, I have made the decision to embark on a guided home nutritional metabolic therapy program to help detoxify my body, strengthen my immune system and improve my health condition. This nutritional approach includes either a complete or modified Gerson Therapy protocol. My spouse or significant other and/or immediate family members are aware of my choice. I am choosing to employ ***Dr. Sarah P. Wilde, GPC, AP*** to assist me in this process by educating, guiding and monitoring my progress through regularly scheduled follow- up consultations, review of lab testing results, imaging studies (if indicated), adjusting my therapy protocols and if or when necessary, recommending appropriate supportive nutritional therapies. I understand that, in some cases, it may be recommended that I pursue further conventional medical work ups or concurrent conventional medical treatments.

I have personally researched this nutritional program and have made my decision freely without coercion. I understand that this non-conventional alternative therapy may not have been investigated, reviewed and/or approved by the FDA or other health authorities, and that there may be no proven benefit over more traditional modalities. **I HAVE BEEN GIVEN NO GUARANTEES OR PROMISE OF SUCCESS, CURE OR REMISSION OF DISEASE PROCESS BY THE APPLICATION OF THIS NUTRITIONAL THERAPY (GERSON THERAPY OR A MODIFIED VERSION OF IT)**.

** Place your initials at each box below:*

*****_____ I understand that by making this decision, **I have assumed COMPLETE and TOTAL CONTROL and FULL RESPONSIBILITY for my decision regarding my choice of how to address my health condition and I WAIVE OR RELINQUISH *Dr. Sarah P. Wilde, GPC, AP* or any affiliated institution or involved parties (in the case of clinical education internship or residency) from any claims, liabilities or legal actions whatsoever that may arise from the said recommendation and/or services or guidance rendered to me**.

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*_____ I understand that *Dr. Sarah P. Wilde, GPC, AP* will maintain my privacy to the highest standards and **will not disclose my personal health information** or personal data to any requesting or attending party unless I have initially given approval in writing.

*_____ I understand that there is **no health insurance coverage** for the services or guidance provided and **I am fully responsible financially**, agreeing to meet my financial obligation **24 hours prior to the date of service** or appointment time.

*_____ I acknowledge **all appointments are set in Eastern Standard Time** and **failure to attend** the appointment **will result in a charge of 50% of the service** as a no-show or late-cancelation fee, **if notice is not given 48 hours in advance**.

Client name (printed)_____

Client signature_____

Witness (person who has Power of Attorney)_____

Today's Date_____ Time_____