



9065 S. Pecos Road • Suite 220 • Henderson • NV • 89074 • (702) 836-0961 (o) • (702) 836-0964 (f)

## Consent and Authorization for Medical Care and Treatment

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**General Understanding:** I understand that DANIEL F. ROYAL, DO, PC (“DR. ROYAL”) specializes and employs diagnostic methods that may be considered to be “unconventional” or “unorthodox”, also known as “alternative” or “complementary” medicine.

**Informed Consent:** I understand that, absent emergency or extraordinary circumstances, no substantial procedures are performed upon me unless and until I have had an opportunity to discuss them with the physician or other health professional to my satisfaction and that I have the right to consent, or refuse to consent to any proposed procedure or therapeutic course. I do consent to allowing my picture to be taken and placed in my patient file for identification purposes. I also consent to ancillary support staff performing diagnostic and treatment procedures on me that are prescribed or recommended by DR. ROYAL.

**Indemnification and Hold Harmless:** I understand DR. ROYAL is an independent contractor with, not an employee of, the Stirling Club. Consequently, I agree to hold the Stirling Club harmless against any and all liability, claims, suits, losses, costs, and legal fees caused by, arising out of, or resulting from any negligent act or omission that may occur in the performance and/or failure to perform medical duties. In connection with any claim, the parties shall cooperate with each other and provide each with access to relevant books and records in their possession, as well as necessary employees or other agents. These indemnification obligations shall continue in full force and effect notwithstanding the termination of treatment by DR. ROYAL.

**Patient Evaluation:** I understand that: (1) blood tests and urine may be ordered to better assess my chemical, hormonal and allergy status; (2) heart rate variability testing may be performed (e.g. to assess physiological functioning); and (3) other tests may be ordered as DR. ROYAL deems necessary to assess and/or monitor my medical condition.

**Patient Treatment:** I understand that DR. ROYAL may prescribe any of the following for my medical condition(s): homeopathics, vitamins, minerals, amino acids, herbs, allergy serums, injections (e.g., intravenous, subcutaneous intramuscular) or other innovative approaches that the DR. ROYAL deems medically necessary for the treatment of my medical condition(s).

Initials: \_\_\_\_\_

**Scientific Research:** I understand that I will not be subjected to any research or experimental procedure without my full knowledge and consent. Nevertheless, I consent to the use of my clinical results and lab reports for research and scientific purposes, to aid in the advancement of medical knowledge, provided my identity is kept confidential.

**Guarantees:** I acknowledge that my treatment with DR.ROYAL does not constitute a guarantee or promise of cure.

**Risks:** I am aware that, because the practice of medicine is not an exact science, my diagnosis and treatment may involve risks of injury. For example, homeopathic medications may cause a temporary aggravation of symptoms and injections can result in localized soreness.

**Insurance:** I understand that DR. ROYAL is a fee-for-service physician, does not belong to a Preferred Provider Program (PPO) or a Health Maintenance Organization (HMO), and does not accept insurance. Thus, I am responsible for all charges incurred with DR. ROYAL, although non-HMO insurance may be submitted for lab work provided I have met any co-pays and/or deductibles. Further, I understand that I may submit only non-HMO medical bills to my insurance company for reimbursement, but full reimbursement is unlikely to occur even in the best of circumstances.

**Payment:** I understand that payment is due at the end of each visit. Major credit cards, check or cash may be used to make payment. In the event of a returned check, I will reimburse NHM, by credit card or cash, for the total of the check and a \$25 service fee. Special payment options must be arranged with DR. ROYAL prior to treatment.

**Medications & Supplements:** I understand that items recommended by DR. ROYAL, which are purchased and removed from the premises, are NOT returnable.

**Governing Law:** This Agreement shall be interpreted and enforced in accordance with the laws of the State of Nevada.

**Severability:** If any term, provision or condition of this Agreement, or any application thereof, should be held by a court of competent jurisdiction to be invalid, void, or unenforceable, all provisions and conditions of this Agreement and all applications thereof not held invalid, void, or unenforceable, shall continue in full force and effect and shall in no way be affected, impaired or invalidated thereby.

**Arbitration:** The parties agree that any claim or dispute arising under or out of this Agreement shall be subject to binding arbitration pursuant to the Commercial Rules of the American Arbitration Association (AAA) and conducted in the City of Las Vegas, Nevada. There shall be a single arbitrator selected by the AAA. In no event shall either party be entitled to punitive damages.

Therefore, I, \_\_\_\_\_, being of sound mind, and having read the above information, fully understand my rights and responsibilities and hereby consent to being a patient with DR. DANIEL ROYAL, DO, PC.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_