

PATIENT NOTICE AND DISCLAIMER FOR ALTERNATIVE INTEGRATIVE SERVICES

Practitioner Name Shalomim Halahawi **Qualifications** NMD-(AM), DNM, D.Psy(PC), DPH, DPHC (MD, DDS, ND etc)

Before seeking or agreeing to services, we ask that you read the information contained herein and make an informed decision about how you wish us to proceed in providing services to you. After reading this complete document, please indicate your decision by marking your choice below, and affixing your signature at the bottom. If you do not understand any part of this document, please ask our staff for clarification, and do not affix your signature until you have a complete understanding and agreement. For purposes of this agreement, ALTERNATIVE NATURAL MEDICINE SERVICES are defined as *any healthcare activity that is not, or may not be commonly practiced, recognized or accepted under conventional state medical licensure.*

We believe in providing the highest level of service possible to each patient, and believe that each individual has God-given and constitutionally mandated freedom to make certain choices, without undue interference or sanctioning by others, including the State. Doctor HaLahawi as a personal choice and sense of responsibility as a Jewish healthcare practitioner, agrees to provide services to you (1) in accordance with licensure, (2) in conformity to Jewish values, (3) in accordance with constitutionally guaranteed rights (4) in accordance with training and experience. Such service may include activities that are considered Alternative and/or Integrative under state licensure, such as the sharing of Spiritual/Natural concepts for good health, thoughts, ideas and advice on safe, natural health supplements, natural medicines and health improvement strategies. We believe that this choice of services is a God given right, not a State regulated freedom.

YOU SHOULD KNOW that State medical licensure incorporates rules, regulations and responsibilities, intended to protect the patient, and unless you CHOOSE otherwise, all services provided to you will be limited to those practices that are in conformity with state license standards. At the same time, you may CHOOSE to receive services that may be considered Alternative or Integrative. If you choose to receive Alternative services, such service will be provided under the conditions set forth below, and are not intended to violate any standards, rules or regulations imposed by licensure, but solely to provide the level of services that you as a patient have a right to seek, and we believe we have a right and responsibility to provide. We reserve the right to refuse services that we believe may not be in the best interest of your health.

***You Have A Choice:** This form, nor any agreement we make is intended to violate any law, right, regulation, responsibility or otherwise, but to enable us to enjoy the rights we do have together, with full understanding and disclosure.*

If you DO NOT wish to receive Alternative Services, and desire that all services provided be limited to those that are in accordance with state licensed standards, please indicate by placing your mark to the left, and affixing your signature below. We will happily comply with your request.

If you DO wish to receive services that may be considered Alternative, please signify by affixing your mark to the left and signing below, after reading, understanding, agreeing and declaring the following:

Notice and Declaration of 9th Amendment and God-Given Rights:

I, the undersigned, hereby declare the following natural and God-given rights, as reserved to the people, under the 9th Amendment to the Constitution of the United States of America, and which rights I reserve as follows:

1. I reserve the right to seek or ask health care questions, medical advice, counsel, information, recommendations, assessments, evaluations, test, treatments, regimens or modalities from the doctor, nutritionist or practitioner of my choice, for any health reason or purpose.
2. I reserve the right, and accept the responsibility that comes with such rights, to make my own decision as to the qualifications of any doctor, nutritionist, naturopath, pastoral counselor or otherwise that I choose as my health advisor.
3. I reserve the right to Freedom of Choice in Medicine in it's most liberal construction, including the right to choose my own diet, obtain, purchase and use any treatment, therapy, regimen, modality, herb, food, medicine or product for any health condition I may have, as evaluated by myself, any doctor licensed or otherwise, and/or any other advisor or therapist.
4. The enumeration, in this declaration, of these rights shall not be construed to deny or disparage others retained by me, or my right to amend this declaration at any time.
5. I completely understand that the doctor or individual practitioner that I choose to seek advice from may provide a service that is, or may not be "proven" or accepted by some as effective, and it is MY choice as stated herein to choose such service. I therefore hold harmless and defend such practitioner to provide such services to me, from any attempted sanction or interference by any other individual, State or otherwise.

I agree that it is my sole responsibility to seek advice from another qualified health professional in the event I deem such necessary, or on the advice of the herein named practitioner to do so.

Patient/Client Name _____
(Last) (First) (Middle) (Maiden)

Dependant Name if dependant or child of above _____

Signature _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E mail: _____

Witness Name: _____ Signature _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____