

Informed Consent of Care

Holistic Health Consulting employs the principles of Traditional Tibetan Medicine to assess and address humoral imbalances, aiming to restore balance in both physical and mental health. Traditional Tibetan Medicine takes a holistic approach, evaluating the entirety of a person's condition and offering personalized recommendations tailored to the individual's specific needs.

Therapies provided by Holistic Health Consulting may include: dietary guidance; lifestyle adjustments; instruction on preparing herbal decoctions customized to the individual's condition; and external therapies, such as oil massages and hot-oil compresses, among other modalities. Under current Maryland law, Traditional Tibetan Medicine is not considered the practice of "medicine" as defined by state regulation and is not governed by state medical boards. This form of health consulting is designed to complement traditional allopathic medical care.

Declarations and Consent to Treatment

Non-Medical Practitioner Acknowledgment

I acknowledge that EzDean Fassassi is not a licensed "medical doctor." I understand that if a medical diagnosis or prescription treatment is needed, it must be obtained from a licensed medical doctor.

_____ (Initials)

Traditional Tibetan Medicine

I understand that the care provided at this clinic is based on the principles of Traditional Tibetan Medicine, which may differ in approach from conventional Western medical treatments.

_____ (Initials)

Understanding of Risks

I acknowledge that, as with any health treatment, there are no guarantees of results. I do not expect Holistic Health Consulting or its practitioners to anticipate or explain all potential risks and complications. I voluntarily consent to the assessments and therapies mentioned above, understanding that outcomes may vary.

_____ (Initials)

Right to Seek Alternative Medical Care

I understand that I am free to seek, or continue receiving, medical care from a licensed physician, surgeon, or any other healthcare provider qualified to practice medicine. No employee or practitioner at Holistic Health Consulting is advising or encouraging me to refrain from seeking the advice or care of another licensed healthcare provider. I recognize that the treatments and therapies offered by Holistic Health Consulting may differ from those typically provided by licensed medical doctors or other healthcare professionals.

_____ (Initials)

Financial Responsibility and Revocation

I understand that I may revoke this authorization for treatment at any time, but I will be financially responsible for any treatment or services rendered up to the point of revocation.

_____ (Initials)

Affirmation of No Agency

I affirm that I am not an agent of any private, local, county, state, or federal agency attempting to gather information without disclosing my agency or affiliation.

_____ (Initials)

I have read, understood, and fully acknowledge the policies and information detailed above. I have received a comprehensive

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explanation of the treatment and services offered at Holistic Health Consulting and hereby consent to receive these treatments. This consent applies to the entire course of my treatment at Holistic Health Consulting, unless revoked by me in writing.

Patient Information:

Patient Name: _____

Patient DOB: _____

Date of Consent: ___ / ___ / ___

Signature of Patient (or Parent/Legal Guardian):
