

Farah Gron, C.Hom, FHom  
New Life Homeopathy, Inc.  
617-731-1400  
farahgron@yahoo.com

### **Agreement to be treated**

I have read and understand the office policies of New Life Homeopathy, Inc. as described in the "Fees and Policies" document

[http://www.newlifehomeopathy.com/Fees\\_Policies\\_Agreement.cfm](http://www.newlifehomeopathy.com/Fees_Policies_Agreement.cfm).

By signing this form, I certify that I agree to the terms of that document. I understand that the fees are not reimbursed by insurance and that I am responsible for paying for services at the time of the appointment.

Client's signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Client or gaurdian's signature if client is under 18 years old)

#### Consent to treat a child (under 18 years old)

I give permission to Farah Gron to treat my child/children with homeopathy for the emotional symptoms that my child is presenting. I have been informed and understand that Farah Gron is not a medical doctor and does not prescribe any medication or diagnostic testing and that I am to continue to have a primary phyisician/pediatrician for my child/children and to continue any medication that has been prescribed by a physician for my child. I understand that Farah Gron does not treat acute problems such as injuries, earaches, infections, colds, flu or emergencies. In the event of an emergency with my child/children, I am to call 911 immediately, go to an emergency care center and/or contact our physician.

Child/Children's name(s): \_\_\_\_\_

Client's name: \_\_\_\_\_

Client or guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Adult client informed consent

I have been informed and understand that Farah Gron is not a medical doctor and does not prescribe any medication or diagnostic testing and I am to continue to have a physician if needed for my health condition and to continue any medication that have been prescribed by a physician. I understand that Farah Gron does not treat acute problems such as injuries, ear aches, infections, colds, flu or emergencies. In the event of an emergency, I am to call 911 immediately, go to an emergency care center and/or contact my physician.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

