RENO INTEGRATIVE MEDICAL CENTER

6110 Plumas St. Suite B

Reno, NV 89519

(775) 829-1009

AGREEMENT CONCERNING SCOPE OF PRACTICE

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

The purpose of this letter and agreement is to explain generally the scope of the services our office will provide to you.

You have come to this office with the desire to improve your general health and the condition of your immune system, through special nutritional support and the use of certain immune-enhancing substances. You should understand that degenerative disease, such as cancer, may or may not be associated with a nutritional deficiency or a failure of the immune system.

Our primary concern in your treatment will be the improvement of your over-all health and in your ability to resist or combat disease through improvement in your nutrition and immune system. **If you don’t have a primary care physician, you can establish with us.** We do not make claims or assurances regarding the effect of any diagnosis, treatment, alleviation or cure disease from which you may be suffering. It will be your obligation to place yourself under the care of a general practitioner or appropriate specialist for the care of any specific disease.

In our nutritional, less-toxic management of a patient, we regularly recommend a variety of vitamins, minerals, homeopathic remedies, enzymes and immune system builders or enhancers. Our purpose in providing our treatment is to improve your nutritional status, overall health and immune system. We do not offer promises to cure a specific disease.

We anticipate, but in no way guarantee, an improvement in your feeling of well-being. It should also be understood that some physicians practicing traditional medicine consider our treatment to be of little or no value and you may even be discouraged by some physicians from seeking nontraditional care.

Electro-diagnostic instruments may be utilized in our treatment to pinpoint various weaknesses, toxins, or underlying illnesses in the body, which impair or slow the healing process. Patients suffering from degenerative disease, including cancer, often harbor some underlying conditions which also need to be eliminated from the body through the use of homeopathic preparations of other means of detoxification. Again our views regarding nutrition and immune system enhancement are provided solely in my capacity as a provider and are not necessarily shared by such conventional organizations as the American Medical Association, the U.S. Food and Drug Administration, the American Cancer Society, the printed and electronic media, the various state medical boards, and the National Cancer Institute, to name a few.

This agreement and the methods employed by this office are applicable to, and in accordance with, the laws of the state of Nevada only, and not necessarily the laws of any other state(s). This office, including all providers, nurses and other personnel, disclaims responsibility for the consequences from the use of any of its methodologies used in any state other than Nevada, or by any provider, nurse, or health practitioner outside of our office.

When you sign this agreement concerning scope of practice you will be signifying that you wish for us to prescribe or administer to you such nutrients, minerals, vitamins, immune system enhancers, biological, homeopathic compounds, hormones, drugs, devices or procedures which, in our sole opinion, as homeopathic practitioners, appear to be indicated in your case.

The terms of this agreement apply to all treatment and care provided to you including that of nurse practitioners, nurses, laboratory technicians, and other office personnel. It shall be interpreted in accordance with the laws of the State of Nevada.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and understand the terms and conditions indicated in this agreement, and hereby consent to the care of Kathy Goldsworthy DNP, FNP-BC, and her staff for nutritional and immune support only.

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

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_