



Homeopathic Medicine
& WELLNESS

Maria Ringo B.GS, DHMHS, CCH, HOM
3230 Yonge St. #1925
Toronto, ON M4N 3P6
t 416-792-2108
w www.nthm.ca
e maria@nthm.ca

Patient Consent Form

I, _____

(please print name of patient if over the age of 18, or the legal guardian seeking care for a minor if patient is under the age of 18)

at the following full address:

willingly consent to homeopathic treatment for myself or my child (please print full name of

child: _____) by Maria Ringo, a licensed member of the College of Homeopaths Ontario. I confirm that there has been no suggestion made to me by Maria Ringo, or by anyone under her direction or control to prevent me from seeking or following conventional medical treatment. The decision to seek homeopathic treatment is solely my decision and I understand that I may still seek the treatment of an allopathic physician or any other health practitioner at any time.

I understand the cost of treatment and agree to pay my account according to the guidelines set by my homeopathic practitioner and that all fees are non-refundable. I understand that as insurance is a benefit negotiated between myself or my employer and the insurance company, that it is my responsibility to pay my homeopathic practitioner directly, and to make any insurance claims on my own behalf.

I understand that all information disclosed herein is confidential and remains within the property of the professional office of Maria Ringo.

I acknowledge that the nature of homeopathic medicine and basic homeopathic processes of treatment have been explained to me sufficiently so that I am willingly giving my consent to Maria Ringo for homeopathic treatments.

Patient signature:

Dated:

Witness: