

# Informed consent

The Virginia Center for Health and Wellness  
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Jacquelyn Meinhardt FNP, Cindy Marck RN

By signing this form I, the undersigned patient, acknowledge that, with respect to services rendered by Dr. Andrew Heyman MD, Dr. Laura Stone MD, Dr. James Yang MD, Jacquelyn Meinhardt FNP, Virginia Center for Health and Wellness (VCHW):

## Physicians Role:

Our doctors are not primary care physicians. VCHW encourages you to have a primary care physician. Our physicians provide specialized, alternative or integrative care adjunctive to primary care. I understand that I am to have a primary care physician, and the primary care physicians contact information is listed below:

Name of Physician: \_\_\_\_\_

Street address: \_\_\_\_\_

Office telephone: \_\_\_\_\_

## Voluntary Consent:

I have been given ample opportunity to ask questions and any questions I have asked have been answered or explained in a satisfactory manner. My consent to using functional medicine, energetic, and other approaches, whether considered conventional or integrative, is given voluntarily, without coercion and may be withdrawn, and I am competent and able to understand the nature and consequences of my decisions.

## No Guarantees:

I am aware that the practice of medicine is not an exact science and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnostic approaches or treatment recommendations that I receive from the Virginia Center for Health and Wellness.

I HAVE CAREFULLY READ THIS FORM AND ACKNOWLEDGE THAT I UNDERSTAND IT. NO REPRESENTATIONS, STATEMENTS, OR INDUCEMENTS, ORAL OR WRITTEN, APART FROM THE FOREGOING WRITTEN STATEMENT, HAVE BEEN MADE.

Signature of Patient or Legal Guardian: \_\_\_\_\_

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