2126 Espey Ct, Ste C
Crofton, MD 21114
410-451-3000 (phone)
667-295-7336 (fax)

Therapeutic Health Associates (THA) Patient Agreement

I verify that I have read (or have had someone read to me) the information contained in the Therapeutic Health Associates Office and Financial Policies and understand the information presented including policies on communicating with the practice, missed and canceled appointments, emergencies, coordination and termination of care, medication refills and the THA fee schedule.

I voluntarily consent to out-patient care at Therapeutic Health Associates (THA) which may include a diagnostic evaluation and routine assessment & treatment modalities. I understand that THA uses an integrative psychiatric and mental health approach to treatment. I understand that in addition to conventional medicine, these recommendations or suggestions may include nutritional changes, supplements, and/or referrals for holistic care such as acupuncture. While many of these treatment options have been available and used for many years, I understand they may not be recognized as standard of care and may be considered investigative and experimental.

I understand that although herbal or botanical products are widely available over-the-counter and are considered safe based on research and history of use, many of them have not been approved by the Food and Drug Administration or widely tested. There is some risk that these products could be harmful, especially if I am allergic to them, which could lead to rare serious complications. I also understand that there can be interactions between herbs and medications which are not well known. While unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This could have serious consequences for some medications including high blood pressure drugs. I will let all of my medical providers know what herbs, supplements and medications I am taking.

Therapeutic Health Associates is not responsible for any negative or adverse reaction to any medication currently prescribed or any supplement that is recommended. THA will make every effort to reduce risks and side effects for all medications and supplements.

I understand that treatment is a joint effort between Therapeutic Health Associates and myself, the results of which cannot be guaranteed.

I understand that I may end treatment at any time and that I can refuse any requests or recommendations made by Therapeutic Health Associates.

I agree to be personally and fully responsible for any financial charges related to services or fees as described in the policies.

Printed Name of Patient: _____ **DOB**: _____

Signature of Patient _____**Today's Date**: _____

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Witness Name/ Title: _____

Witness Signature: _____ Date: _____