C.C. MEDICAL SERVICES
Dr. Christopher Calapai, DO
1101 Stewart Ave
Suite 201
Garden City N.Y.11530
P (516) 794-0404 F (516) 794-0332

PATIENT CONSENT FORM

*Patient Name______________________________ *Date______________

1. The approach that will be followed by Dr. Calapai to treat my illness has been explained to me I understand that Dr. Calapai's approach involves a nutritional assessment and holistic approach to my illness.

2. Dr. Calapai's recommendations may include oral as well as intravenous vitamin and mineral treatment, chelation, prolotherapy. I agree with this approach and authorize Dr. Calapai, his associates or assistants to follow such approach.

3. I have been advised and understand that I have the right to choose or reject any treatment or medications recommended by Dr. Calapai. I also have been advised and understand that, while vitamins / supplements recommended by Dr. Calapai may be available for purchase at this office, I may obtain them wherever I choose.

4. I have been informed that the approach Dr. Calapai will follow to treat my illness may not be considered medically necessary, or may be considered non conventional by my insurance carrier and therefore, may not be covered under the terms of my insurance poliy.

5. I understand that Dr. Calapai <u>does not</u> do Emergency Medicine or admit patients to hospitals. I understand that <u>I should have a primary / internist</u> for these needs.

6. Unless Dr. Calapai has otherwise advised me in writing, he is serving in a consultant and <u>NOT</u> as a primary care physician.

7. I understand that I am financially responsible for all charges incurred at Dr.Calapai's office.

8. I understand that patients have a variety of underlying causes of symptoms and problems. Patients can have a varying response to treatment and recommendations. That other patient's results are not a guarantee of future responses or results in other patients.

*Signature of Patient____

* NAME___________________________________

(please print all information)

*Pharmacy Name___________________________

Address__________________________________

City_____________________________________

State_______________ Zip Code____________

* Telephone______________________________

Please provide us with a list of your medications and dosage

* Medication/Dose

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