MINDFUL HEALTH CENTER
FOCUS ON WELLNESS, NOT ON ILLNESS
PETER FISCHER H.C., M.S., D.M.D., PH.D.

INFORMED CONSENT FORM

I understand that the state of Texas issues licenses to health and wellness professionals authorizing them to analyze, assess, diagnose, evaluate, examine and investigate their patients to determine what's wrong with them. This license also authorizes them to advise, caution, counsel, guide, prescribe, recommend and suggest cures, drugs, interventions, remedies and treatments to address what's wrong with them. I understand that Dr. Peter Fischer will refer me to a properly licensed professional if I need -- or if I feel I need -- a specialist to diagnose, treat, counsel or cure me of anything.

I understand that Dr. Peter Fischer is a certified Biofeedback Specialist with the Natural Therapies Board and a certified Health Coach with the American Association of Drugless Practitioner who uses biofeedback/ neurofeedback techniques to help me
manage

- my stress or
- my pain or
- my weight or
- detoxify my body from toxic pollutants or
- improve my peak performance and
- to enhance the quality of my life.

I also understand biofeedback is intend to help me relax. With that help I can learn to manage my stress, pain, weight, bring my mind and body in balance, improve mental performance and enhance my life and health care.
I also understand that nutrition can help me reduce my stress , manage my pain, manage my weight, remove heavy metals and toxic chemicals from by body, improve mental functioning/ mental performance, bring my mind and body in balance and improve the quality of my life.
I also understand that acupressure can help me reduce my stress , manage my pain, manage my weight, bring my mind and body in balance and improve the quality of my life.

I understand that I am responsible for my own health, healing and wellbeing, natural healing is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.
I understand it is my responsibility to advise Dr. Peter Fischer of anything that might help us work together better to achieve the healing I seek.
I understand that dietary supplements may play a role in supporting, affecting, and maintaining overall wellness and specific body structures and functions.
I understand my own health and wellness is my responsibility. Therefore, I agree to use the services of Dr. Peter Fischer to help me learn how to:

- reduce my stress
- reduce my pain
- manage my weight
- improve my mental performance
- balance my mind and body

I understand and I'm agree that my well being and health is my own responsibility. Dr. Peter Fischer's only responsibility is to help me to the best of his ability using his skills and talent including using his coaching tools and coaching techniques.

I understand that if I have -- or if I think I have -- a medical concern, condition, disease, disorder, issue or symptoms, Dr. Peter Fischer will help me reduce any related stress and refer me to a licensed chiropractic, medical or osteopathic physician for further assistance.

I also understand if I have -- or if I think I have -- a psychological or emotional concern, condition, disease, disorder, issue or symptoms, Dr. Peter Fischer will help me reduce any related stress and refer me to a licensed counselor, psychologist or psychiatrist for further assistance.

I acknowledge that I have read and understand this form. I agree to allow Dr. Peter Fischer to help me learn to heal myself using the natural healing techniques and modalities herein listed.
I acknowledge that I have read and understand this form. I agree to allow (your name) to help me allow and accept Divine healing using the spiritual healing techniques and modalities herein listed.

I have read and understand this form. I agree to pay Dr. Peter Fischer for teaching me how to accept Divine healing using the spiritual and natural healing techniques and modalities listed in this form.

CLIENT CONFIDENTIALITY

I understand Dr. Peter Fischer will keep all information he learns about me completely confidential unless I release him in writing or as required by law.
I further understand Dr. Peter Fischer will not acknowledge my presence or discuss anything with me publicly unless I initiate the conversation and the topics of discussion.
I understand my identity and any information about me, whether I share it with Dr. Peter Fischer or he discovers it on his own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.
I have read the form and understand the content of the form.
I accept your services on the basis of this information and decided to sign this form of my own free will

Your signature below indicates that you have read and understood the information in this document and that you consent to biofeedback training under the provisions stated. If you do not understand or consent to anything stated in this document, it is your responsibility to request and receive clarification before signing.

Name of Client_____

Address_____

State_____Postal Code_____Country_____

Signature_____Date_____

Name if other than client_____

Relationship to client _____

FOR PARENTS/GUARDIANS OF MINOR CLIENT
I attest that I have full legal authority to make decisions for the minor named below, and that I give my permission for him/her to undergo biofeedback training.

_____

Parent/Guardian's Signature Minor's Name Date