



SUNRISE
FUNCTIONAL MEDICINE

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Consultation Informed Consent Form

*(If consulting for minor child or disabled adult who is incapable of making health decisions for themselves both legal guardians or the person with legal authority to make medical decisions **MUST** sign this document).*

Name (print) I, _____
(or the individual named here for whom I am legally responsible), hereby request and consent to receive care from Dr. Kurt N. Woeller (aka Dr. Woeller) and/or Dr. Tracy Tranchitella, (aka Dr. T) of Sunrise Functional Medicine, (herein after referred to as “the doctors”).

Established Patient

I understand the doctors are licensed in the State of Oregon and I (or my child) can visit either doctor in person, in Oregon, so that I (or my child) become an “established patient.” I also understand that obtaining a health education information consultation via phone or internet video consultation, e.g., Zoom, service does not establish me (or my child) as a patient if I (or my child) have not seen the doctors in person first.

Functional and Integrative Medicine

I understand the doctors may employ “alternative” (aka biomedical intervention, complementary, functional, integrative, holistic, naturopathic, non-traditional) care methods, including nutritional, herbal and homeopathic supplementation, compounded medications, alternative diagnostic testing methods to evaluate for food sensitivities, intestinal pathogens, metabolic imbalances, environmental exposure, etc. I acknowledge that I am specifically seeking the doctors’ specific knowledge in these areas.

I understand the doctors may employ interventions that may not always be considered “Evidence Based Medicine” (EBM) by some in the conventional medical community. EBM relies heavily on peer-reviewed research and clinical trials. Not everything in “alternative” medicine can be deemed EBM, as it relies on doctors’ clinical experience with a particular therapy or hasn’t been fully funded or peer reviewed through research. This doesn’t mean therapies and testing that are not viewed as EBM are not effective or are dangerous but provides other options for health improvement.

I agree that there are various definitions of “Evidence Based Medicine” and often they are too constrictive for my personal health pursuits and wish to broaden the therapeutic and diagnostic options for myself (and/or my child). I understand that these “alternative” methods under some circumstances could aggravate pre-existing conditions, and produce a range of side effects, such as allergic or hypersensitivity reactions to botanical medicines, nutritional supplements (which can come from plant, animal, mineral and other sources), and medical foods. Under rare conditions, severe illness could result. I willfully choose to explore this expanded approach to uncover root causes and therapeutically address my (or my child’s) health issues with the goal to improve and/or overcome said health issues.

Personal Responsibility

I request and agree to have the doctors provide their interpretation skills for my (or my child’s) laboratory testing and provide their suggestions for health improvement, but that I am solely responsible for doing my own research, asking for second opinions from other health professionals if I choose, and sharing information with my (or my child’s) personal primary care doctor before implementing any diet, nutritional supplements or lifestyle change suggestions.

I understand that botanical and nutritional supplements, homeopathic remedies, and medical foods that may be suggested, are largely considered safe when taken as directed. I am aware that it is extremely important that I follow the suggested dosing instructions when taking recommended supplements, hormones, medications, and medical foods, etc. as some items could be toxic or counterproductive when taken in large doses or not as directed.

I understand that all these substances need to be prepared and consumed according to the instructions provided orally and in writing. Some products may be inappropriate during pregnancy or prior to surgery, and I will immediately notify the doctor if I become aware that I am pregnant or am planning a surgical procedure. Because of the possibility of adverse drug-herb interactions, I agree to inform the doctor of all drugs – prescription and recreational – and herbs I am currently taking.

I agree to maintain my own primary care physician, or my child’s pediatrician (primary care doctor) with the understanding that Dr. Woeller and/or Dr. Tranchitella do not provide primary health care or “after hours” coverage for emergencies.

I understand the doctors are not diagnosing disease or treating a disease process, but instead making recommendations to help improve my overall health, vitality, immune and other organ system function.

I understand that certain health conditions may not be recoverable, and I do NOT expect Dr. Woeller and/or Dr. Tranchitella to guarantee absolute resolution and cure of my (or my child’s) health condition.

Health Education Consults

It is my understanding that consulting with the doctors via phone and/or internet, e.g., Zoom without having seen them in person does not constitute them as “treating doctors.” In this role they are acting solely as a health education information consultant for providing suggestions, ideas, and feedback based on their clinical and professional experience for health improvement. The doctors cannot provide prescriptions for individuals they have not physically seen in-person, if out of state, or overseas.

Health education consults are not intended to:

- *Diagnose or treat any disease or condition.*
- *Manage health care.*
- *Provide medical services.*
- *Initiate a doctor-patient relationship.*

If laboratory data is assessed or obtained, suggestions may be set forth for health information only based on the objective data from the lab test. However, this does not constitute a specific diagnosis.

It is my understanding that consulting via internet, e.g., Zoom, cellphone, or hardline phone may not be 100% secure from privacy invasion. I accept and acknowledge this reality for the purpose of convenience and time efficiency in consulting with the doctors through telehealth avenues.

Any application of suggestions set forth via my consultations with the doctors for my personal (or my child’s) health care such as the use of supplements, herbs, dietary changes, medications, and/or lifestyle changes is done so at my sole risk and responsibility.

If 18 years and older (legal adult):

Signature: _____ Date: _____

If a representative is signing on behalf of the individual (whether they are a minor child or disabled adult who is incapable of making personal medical decisions) please indicate the nature of your relationship to the individual. All parents or legal guardians must sign. Please note that these signatures constitute consent for consultation, education, and/or treatment.

Mother:

Do you have *legal medical decision-making authority*? (check 'yes' or 'no'): ____ Yes ____ No

Print Full Name: _____

Signature: _____ date: _____

Father:

Do you have *legal medical decision-making authority*? (check 'yes' or 'no'): ____ Yes ____ No

Print Full Name: _____

Signature: _____ date: _____

Other Caregiver or Parent:

Do you have *legal medical decision-making authority*? (check 'yes' or 'no'): ____ Yes ____ No

Print Full Name: _____

Signature: _____ date: _____

Legal Custody (must indicate who has legal custody):

If parents of the minor child are not married, who had legal custody?

With whom does minor child live with?

If individual is a disabled adult, where do they live? _____
