



THE MAAS CLINIC

OSTEOPATHIC & FUNCTIONAL DIAGNOSTIC MEDICINE

Henley House, Upton, St. Michael BB11103 Barbados

Tel: (246) 431-9415 Fax: (246) 435-8456

Consent Forms

IMPORTANT PATIENT INFORMATION

Patient Acceptance Policy

In order to best serve you, the *Patient Acceptance Policy* should be carefully reviewed. It is **The Maas Clinic's** opinion that you should be well informed on our expectations and clinical procedures. To prevent any misunderstandings or confusion on what to expect, **The Maas Clinic** would appreciate that you read the below steps and provide your signature. This would simply imply that you have read the *Patient Acceptance Policy* and understand what is expected of you.

1. Completion of the following forms:

- The Health Questionnaires**
- The Nutritional Assessment Questionnaire** This 322 question questionnaire was developed to gather important information about your body. It will help **The Maas Clinic** to assist in helping you. The medical questionnaire will allow **physician** to quickly “zero” in on the probable causes of your health problems.
- The Diet Diary**

It is **VERY** important for you to carefully and thoroughly complete all of these forms and questionnaires 48 hours prior to your first consultation with **The Maas Clinic**. If the forms are not completed and submitted in the requested time then your appointment will have to be re-scheduled.

2. Medical Records from all physicians since you were **first diagnosed** with your health condition should be obtained prior to scheduling an appointment. This will assist the physician with your detailed health history.

3. Once **The Maas Clinic** has your completed questionnaires and copies of all your medical records, a half hour appointment will be held to review your case..

4. Based on your scheduled appointment and review of all your medical information, it may be necessary to obtain **comprehensive blood chemistry**. The blood chemistry test will include:

- Basic Metabolic Panel:** includes 10 important disease markers. This test measures glucose levels, electrolyte & fluid balance & kidney function
- General Chemistry 13 Panel:** includes 13 important markers. This test measures the kidney, liver & gallbladder function
- Lipid Panel:** includes 6 important markers. This test measures the lipids (fats) and fatty substances in the body
- Single Test Strips:** these individual strips spot check markers for cholesterol, glucose, haemoglobin etc
- Blood Type Test Kits:** these individual kits are to determine blood type

5. Based on your medical history, questionnaire, medical records and initial consultation, it may be necessary to order additional medical laboratory tests. You will be presented with detailed information on the **specific tests recommended**. The cost for your initial Laboratory tests will be discussed at that time. **Payment can be made via check and/or credit card.** We accept **Visa and Mastercard**.

6. The results of your in house lab tests are provided at test time. This appointment usually takes approximately one to one and half hours. You will be presented with a report **detailing the results of your tests, the possible causes of your health problem and the recommended treatment protocol**. It is recommended that you have your spouse or a supportive family member attend this appointment.
7. Your treatment may consist of dietary and lifestyle changes as well as prescribed **Natural Pharmaceuticals**, which must be paid at the time of purchase.
8. It is strongly recommended that you have access to a computer with Internet Connection. **A progress medical questionnaire** will be posted to your e-mail one week before your next scheduled appointment. Completion of the progress questionnaire is required every 2-6 weeks to monitor your progress. Correspondence by e-mail is strongly encouraged and is **Free of Charge**. If you do not have access to the internet, then a copy of the progress questionnaire will be mailed or faxed. If you would prefer to schedule an appointment to discuss any questions, you may do so by calling the clinic.
9. Follow-up consultations will be scheduled every **2 to 12 weeks** allowing you the opportunity to discuss your progress and any concerns with **The Maas Clinic**. **The Maas Clinic** will at this time determine what direction to take to help you continue your progress. Your cooperation in taking **“personal responsibility”** in your health care will go a long way in getting better. Consultations can be conducted either by phone or in person (at the clinic), our reception team will specify what is required.
10. **Abnormal laboratory tests** will need to be re-evaluated. The success of your treatment will not only be measured on the reduction of elimination of your physical symptoms, but on abnormal laboratory tests returning to a normal status.
For example: Many physicians will prescribe Lipitor for individuals suffering with high cholesterol. Your physician will also require periodic cholesterol blood tests to monitor the success of the medication. Laboratory fees can vary depending on what needs to be re-tested.

I, _____ have read and fully understand the **Patient Acceptance Policy**

Patient Signature

The Maas Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting Records of Doctor:

Name of Facility or Person: _____

Address: _____

Telephone number () ___ - _____ Fax number () ___ - _____

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to **The Maas Clinic** all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information. I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: Yes No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: Yes No

Genetic Testing Yes No

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release **The Maas Clinic**; its employees, agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

Patient's Name: _____ D.O.B. _____
Please Print

Signature: _____ Date _____

PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE OR PASSPORT ALONG WITH THE COMPLETED AND SIGNED FORM

Records Requested by:

Doctor's Name: **The Maas Clinic – Laurens Maas**

Address: Alcott, Worthing, Christ Church BB15008 Telephone number: (246) 431-9415

Signature: _____