INFORMED CONSENT FORM

Linus Pauling Prevention Center – Dr. Werner Faché

1. Information Provision

I, the undersigned, ..., declare that I have been clearly and understandably informed by Dr. Werner Faché, a licensed general practitioner specialized in lifestyle medicine, with expertise in biogerontology and nutritional medicine, about:

- the nature, purpose, importance, and course of the proposed consultation, examinations, treatments, and/or follow-up;
- the expected results, possible risks, and inconveniences;
- the financial implications and cost.

I confirm that, prior to signing this form, I have received, read, and understood Annex 1 (overview of fees and costs).

I understand that Dr. Werner Faché is not conventioned, meaning that consultation fees fall outside the RIZIV/National Health Insurance system. This means that no reimbursement through the health insurance fund is possible for these consultations. Fees for consultations related to examination(s), treatment(s), and/or follow-up generally range between €150 and €400, depending on the services provided and the time spent.

I understand that the health insurance only provides reimbursement for:

- a routine basic blood test;
- prescribed external medical imaging (subject to copayment and any legally applicable supplements);
- prescribed medications that meet the legal reimbursement conditions.

I understand that the health insurance does not reimburse for:

- specific diagnostic sampling kits;
- laboratory analyses outside the RIZIV nomenclature;
- dietary supplements.

If I wish to purchase certain dietary supplements via specialized webshops, I may make use of any publicly available discount codes from the supplier. Dr. Werner Faché is not affiliated with these webshops, receives no remuneration or benefits, and provides this information solely to support accessibility. I am entirely free to choose my supplier or pharmacy.

2. Consent Statement

I have had sufficient opportunity to ask questions, and all my questions have been answered to my satisfaction.

Patient name: .....

Date: .....

Patient signature (preceded by “read and approved”): .....