

INFORMED CONSENT FORM

Linus Pauling Prevention Center – Dr Werner Faché

1. Provision of information

I, the undersigned, ..., declare that I have been informed in a clear and understandable manner by Dr Werner Faché, accredited general practitioner specialised in lifestyle medicine, with expertise in biogerontology and nutritional medicine, about:

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

I confirm that, prior to signing, I received, read and understood appendix 1 (overview of fees and technical services).

I understand that Dr Werner Faché operates outside the national fee agreement (niet-geconventioneerd) and that consultation fees fall outside the RIZIV/INAMI system. This means that no reimbursement through the health insurance fund is provided for these consultations. Fees for specialised consultations generally amount to € 300–500, depending on the complexity of the file, the services provided and the time spent.

I understand that the health insurance only contributes towards:

- a routine basic blood test;
- prescription-only external medical imaging, subject to the patient's own contribution and any statutory supplements;
- prescription-only medicines that meet the statutory reimbursement conditions.

I understand that the health insurance does not contribute towards:

- specific diagnostic sampling kits;
- laboratory analyses outside the RIZIV/INAMI nomenclature;
- nutritional supplements.

If I wish to purchase certain nutritional supplements through specialised online shops, I may make use of any publicly available discount codes offered by the supplier. Dr Werner Faché is not affiliated with these online shops, receives no remuneration or other benefit for this, and provides this information solely to support accessibility. I am entirely free in my choice of supplier or pharmacy.

2. Declaration of consent

I have had sufficient opportunity to ask questions and my questions have been answered to my satisfaction. I give my consent for the consultation, investigations, treatments and/or follow-up described above, as discussed with me.

Patient's name:

Date:

Patient's signature (preceded by "read and approved"):

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