INFORMED CONSENT TO TREATMENT

HealthSource INTEGRATIVE MEDICAL CENTRE

It is very important that you inform your naturopath immediately of:

- any disease process that you are suffering from
- if you are on any medication or over the counter drugs.
- if you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, infection or injury from venipuncture, acupuncture, parenteral therapy or cupping
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa or cupping
- Muscle strains and sprains, disc injuries from spinal manipulation.
- There is a very small potential for stroke is a concern in neck manipulation. Patients are thoroughly screened by the intern prior to manipulating the neck.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fee be protected and kept confidential.

I understand that my naturopathic doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise judgement during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below): _____

_____

I intend this consent form to cover the entire course of treatment for my health conditions I am seeking treatment for. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive with my Naturopathic Doctor and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as other applicable fees.

Patient's Full Name: _____
(Please print) First Middle Last

Date of Consent: _____

Signature of Patient: _____
(or Parent/Legal Guardian)

Naturopathic Doctor: _____