Informed Consent Form

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Your Naturopathic Doctor will take a thorough case history and perform a relevant physical examination. It is very important that you inform your Naturopathic Doctor of any medical concerns or medication and supplements you may be taking. Please advise your Naturopathic Doctor if you are pregnant, suspect you are pregnant or if you are breast- feeding. As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected beneﬁts, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine including acupuncture. By signing at the end of this you acknowledge your understanding of the associated risk and grant permission to proceed. Possible side effects of naturopathic medical care include:

• Aggravation of pre-existing symptoms  
• Allergic reactions to supplements or herbs   
• Pain, bruising or injury from acupuncture   
• Fainting or puncturing of an organ with acupuncture needles

I understand that a conﬁdential record will be kept of the health services provided to me. This record will be kept conﬁdential but if required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers. I understand that I may look at my medical record at any time and can request a copy of my ﬁle with a fee of $0.10 per page. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept conﬁdential.

I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate all risks and complications. With this knowledge, I voluntarily consent to Naturopathic care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient Name: (Please print name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Naturopathic Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ND Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_