One Earth
Natural Medicine Clinic

NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Susan Jones, Naturopathic Physician, to perform or order the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, UA, Pap smears, radiography, laboratory
Minor office procedures: e.g., wound dressing, ear cleansing
Naturopathic physical medicine: e.g. craniosacral technique, muscle energy stretching, therapeutic massage techniques, heat and cold therapies, therapeutic ultrasound and other related treatments
Medical use of nutrition: therapeutic nutrition, nutritional supplementation, intramuscular vitamin injections
Western Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, gels, or suppositories
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses
Lifestyle counseling: promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work, spiritual awareness, and social activities
Psychological counseling
Contraception: e.g. OCPs, diaphragms, cervical caps
Flower Essence formulas

I recognize the potential risks and benefits of these procedures as described below:
Potential risks: allergic reactions to prescribed herbs and supplements; side effects of natural medicines; inconvenience of lifestyle changes; injury from injections, venipuncture, or physical medicine.
Potential benefits: restoration of health and the body's maximal capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. In the potential case that I find fault with Dr. Susan Jones and decide to seek legal action, I consent to settle with arbitration, rather than trial by jury.

Signature of Patient_____ Date: _____

Signature of Legal Guardian_____ Date:_____

Susan Jones ND
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