

**NATUROPATHIC MEDICINE  
INFORMED CONSENT FOR TREATMENT**

I, \_\_\_\_\_, hereby authorize Susan Jones, Naturopathic Physician, to perform or order the following specific procedures as seen fit and necessary with in medically necessity 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: \_\_\_\_\_