

# NATUROPATHIC INFORMED CONSENT TO TREAT

Patient Name: \_\_\_\_\_

Office Name: Natural Choices Health Clinic / Dr Keivan Jinnah, ND, MSOM, LAc.

**Consent:** I hereby request and consent to the performance of naturopathic treatments and / or other naturopathic procedures, including various modes of physical therapy and diagnostic procedures, on me (or on the patient named above, for whom I am legally responsible) by the doctor of naturopathy named above and/or other licensed doctors of naturopathy who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of naturopathy named above, including those working at the clinic or office listed above or any other office or clinic whether signatories to this form or not.

**Type of Care:** I have had an opportunity to discuss with the doctor of naturopathy named above and/or with clinic personnel the nature and purpose of naturopathic care and procedures. A description of the specific care which is currently contemplated follows:

**Homeopathic, herbal, nutritional, and lifestyle treatment.**

**No Guarantee:** I understand that results are not guaranteed.

**Recital of Risks:** I understand and am informed that, as in the practice of medicine, in the practice of naturopathy, there are some risks to treatment, including, but not limited to:

**Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of**

**consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional**

**therapies, hydrotherapies, allergic reaction to prescribed herbs, supplements, prescription**

**medication; soft tissue or bony injury from physical manipulations; aggravation of pre-existing**

**symptoms.**

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.”

**Agreement and Continuous Effect:** I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)