

INFORMED CONSENT FOR NATUROPATHIC TREATMENT

I hereby authorize Dr. Lena Kian, Naturopathic Doctor, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures: general physical exams and laboratory evaluation.

Herbs/Natural Medicines: prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms.

Homeopathic remedies: often highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements for treatment.

Physical Therapy: therapeutic massage, muscle energy stretching, hot and cold therapies, exercise demonstrations.

Lifestyle Counseling: promotion of wellness including recommendations for exercise, sleep, stress reduction.

I understand the potential risks and benefits of these procedures as described below:

Potential Risks: adverse reactions to prescribed herbs or supplements, including interactions with certain allopathic medications or lab evaluations, aggravation of pre-existing symptoms, pain or no improvement of symptoms, injury from physical therapy, inconvenience of lifestyle changes.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of 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, since 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 my Naturopathic Doctor regarding cure or improvement. 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 procedure and treatment, that is based on the information known at the time and is in my best interest. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. 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 me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request. I have also read and understand (and been furnished with a copy if desired) the **Harmony Healing Naturopathic Clinic Notice of Privacy Practices**, which discuss these and my other rights under the Health Insurance Portability and Accountability Act of 1996.

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's Name (PRINT)

Guardian/Personal Representative's Name (PRINT)

Patient's Signature

Guardian/Personal Representative's Signature

Date

Relationship/Representative's Authority

Date