NORFOLK CHIROPRACTIC WELLNESS CENTRE

INFORMED CONSENT FOR NATUROPATHIC TREATMENT

(Please print out)

Naturopathic Medicine is system of health care that treats and prevents diseases by natural means. Naturopathic doctors (hereinafter referred to as “ND”) assess the whole person, and promote health by assisting the body's own healing mechanisms. Your naturopathic visit may consist of a thorough case history and a screening physical examination, which may include a breast exam. Lab tests and more specific specific examinations such as gynecological, rectal, prostate or genital exams may be necessary and performed by your ND or referred to your Medical doctor. NDs use a broad range of natural therapies including clinical nutrition, lifestyle counseling, botanical medicine, Traditional Chinese Medicine and acupuncture, homeopathic medicine, and physical medicine.

STATEMENT of ACKNOWLEDGEMENT

I understand that the form of medical care is based on naturopathic principles and practices. I will inform the ND of all my health concerns, allergies, medications, supplements, and medical interventions, because safe care requires that I truthfully and completely disclose this information. I will also inform the ND if I become pregnant and/or if I am breastfeeding.

I understand that although naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to:

- Occasional aggravation of pre-existing symptoms by homeopathic remedies.
- Allergic reactions to certain supplements and herbs.
- Pain, bruising or injury from acupuncture, intramuscular injections or venipuncture.
- Fainting or puncturing of an organ with acupuncture needles.
- Muscle strains and sprains or disc injuries from spinal manipulation.
- A very small potential for stroke in neck manipulation.

I understand:

- Any questions I have will be answered by the ND to the best of their ability.
- I do not expect the ND to be able to anticipate and explain all risks and complications and wish to rely on them to exercise judgement during the course of any and all diagnostic procedure(s) and or therapeutic procedure(s)/plan, which the ND feels at the time, based upon the facts then known, are in my best interest.
- Treatment results are not guaranteed.
- I am always at liberty to seek or continue care from another qualified health care provider(s).

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic procedure(s) and or therapeutic procedure(s)/plan and have discussed to my satisfaction this and any requests for related information with the ND named below and/or with her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the diagnostic procedure(s) and/or therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.

PATIENT CONSENT

I have read and understand the above-stated statements, policies and information. As a result, I do hereby voluntarily grant my informed consent for the recommended diagnostic procedure(s) and/or therapeutic procedure(s)/plan outlined above. I intend for this consent to allow for these diagnostic procedure(s) and/or therapeutic procedure(s)/plan to be performed by my primary ND (indicated below), and by other NDs (listed below) in the office, if necessary, for scheduling reasons or for continuity of care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my voluntary informed consent and to discontinue participation in these procedures at any time.

☐ Dr. Laura Vanderaa, ND ☐ Dr. Kathleen Westlake, ND

To be completed by Patient/Parent or Guardian (for patients <14 years of age)/Lawful Representative

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Patient's Name (printed in block letters)

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Signature of Patient/Parent or Guardian/Legal Representative Date Signed

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Witness Signature Date Signed

Witness Relation to Patient: