Snohomish Naturopathic Clinic
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Achieve Optimal Health

Informed Consent for Treatment

Consent: I hereby request and consent to the performance of naturopathic treatments and / or other procedures, including various modes of evaluation and treatment procedures (including, but not limited to those listed below), on me (or on the patient named above, for whom I am legally responsible) by the doctor of naturopathy or, as designated by the doctor of naturopathy, other employees of this clinic, whether signatories to this form or not.

Type of Care: I have had an opportunity to review all of the naturopathic care and procedures listed. I have initialed next to the description of the specific care which is currently contemplated:

_____ **Common diagnostic procedures:** venipuncture, laboratory, Pap smears, or radiography**.**

_____ **Minor office procedures:** dressing a wound, ear lavage, hyfrecation, and intermuscular vitamin or hormone injections.

_____ **Medicinal use of nutrition:** therapeutic nutrition, diet therapy or nutritional supplementation.

_____ **Botanical medicine:** botanical substances may be prescribed as teas, alcohol-based tinctures, capsules, tablets, creams, plasters, or suppositories.

_____ **Homeopathic medicine:** the use of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

_____ **Lifestyle counseling and hygiene:** promotion of wellness including recommendations for diet, exercise, sleep, stress reduction, etc.

_____ **Psychological counseling**

_____ **Contraception:** cervical cap and diaphragm fitting, prescription of oral contraceptives, natural family planning. .

_____ **Acupuncture and Acupressure:** The insertion of pre-sterilized, disposable needles or manual pressure through the skin into the underlying tissues at specific points on the surface of the body.

_____ **Trigger point injections**: The injection of lidocaine through the skin into the underlying tissues at specific points determined by exam and symptomology.

_____ **Platelet Rich Plasma Injections**: The injection of concentrated platelets to areas of concern including face, hands, hair follicles, joints, genitals, etc. for tissue regeneration.

Scope of Care: The practitioners at The Snohomish Naturopathic Clinic do not make recommendations for medical treatments or pharmaceuticals, or for the discontinuation of other treatments and/or procedures with other health care professionals that are not within their scope of practice. Patients that require such treatments will be referred appropriately.

No Guarantee: I understand that results are not guaranteed.

Recital of Risks and Benefits: I understand and am informed that there are both risks and benefits to treatment, including but not limited to:

- **Potential Risks:** allergic reactions to prescribed herbs/supplements or recommended foods, side effects of natural medications, inconvenience of lifestyle changes, muscle or joint soreness, injury from injections, yoga, personal training, venipuncture or procedures. Discomfort, pain, bruising, blistering, bleeding, infection at the site of the procedure, temporary discoloration of the skin, broken needle, possible aggravation of symptoms existing prior to the acupuncture treatment.
- **Potential Benefits:** restoration of health and the body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, prevention of disease or its progression, prevention of injury, and increased self-awareness and knowledge of lifestyle factors that affect ones health.
- **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.

I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise judgment during the course of the procedure which the provider feels at the time, based up on the facts then known, and is in my best interests. I understand that I will be an active participant in my (or my dependent's) healthcare and that I will have the opportunity to withdraw my consent and to discontinue participation in these procedures at any time.

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/Patient representative Signature	**PRINT Patient Name**	**Relationship to Patient**	**Date**