NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Dr. Kate D'Archangel, ND, and her covering physicians, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment.

Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, and laboratory, x-ray.
Minor office Procedures: e.g., dressing a wound, ear cleansing.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Botanical Medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, 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 and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Psychological Counseling
Contraception
Immunization
Pharmaceuticals: e.g., antibiotics, hormones, and other pharmaceutical medications

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 medications, inconvenience of lifestyle changes, injury from infections, venipuncture or procedures.

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 as some of the therapies used could present a risk to the pregnancy.

Payment Policy: Payment is due at the time of service. Cancellations must be made at least 24 hours in advance or patient will be billed for full amount of appointment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Kate D'Archangel, ND, or any of her personnel, 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 practitioner will answer any questions I have to the best of her ability.

Notice of Privacy Practices -- Acknowledgment
I understand that a record will by 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 my representative or myself or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I may also ask to correct that record. I understand that my medical record will by kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research or educational purposes, and that my identity will be protected and kept confidential. (Our **Notice of Privacy Practices** is available to you and describes in more detail how your health information may be used and disclosed, and how you can access your information.) By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Date Signature of Patient

_____
Signature of Patient Representative or Guardian

Original to: Chart
Copy to: Patient (if requested)