This is a suggested sample for use in developing an informed consent form and is for reference purposes only. This document does not establish a standard of care. It is intended for use as a tool to reduce malpractice risk and should be edited to fit your practice and to meet the legal requirements of your individual state(s). It is also intended to improve communication with patients so they may better understand the recommended treatment. **NCMIC advises all Naturopaths to use their clinical judgment in determining the need for informed consent and the content of such a form.**

Informed Consent Document

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of Naturopathic medicine.

The primary treatments used by doctors of naturopathy are natural, non-invasive techniques which stimulate the body's natural healing capacity. Naturopathic medicine is considered a complement to traditional allopathic medicine. We will use clinical nutrition, botanical medicine, homeopathic medicine, lifestyle counseling and physical medicine to treat you.

Analysis / Examination / Treatment

As a part of your case history you are consenting to the analysis, examination, and treatment recommended by our clinic. This may include a basic/complaint oriented physical examination including specific urine and/or blood laboratory tests.

The material risks inherent in Naturopathic medicine.

As with any healthcare procedures, there are certain complications which may arise during even the most basic of Naturopathic treatments. These complications may include, but are not limited to, aggravation of pre-existing conditions, allergic reactions to supplements or herbs, complications in certain physiological conditions such as pregnancy, lactation, those on multiple medications, young children, elderly patients, or those with specific diseases such as heart, liver, kidney, cancer, or diabetes. Complications from any manipulative therapy provided include, but are not limited to, fractures, disc injuries, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor of such conditions. Please advise the Doctor if you are pregnant, suspect you are pregnant, are trying to become pregnant, or if you are breast-feeding. I understand that my Doctor will answer any questions that I have to the best of their ability. I understand that, as with any type of treatment, results cannot be guaranteed. I do not expect my Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the assessment and therapeutic procedures/treatments recommended by the Doctor.

Notice: All female patients must alert the Doctor if they know or suspect they are pregnant as some of the therapies used could present a risk to pregnancy. All individuals with bleeding disorders, pace makers, and/or cancer must also alert the Doctor.

_____ (Initials)

The relationship with other healthcare providers.

Naturopathic Medicine may be a complement to traditional allopathic medicine. I acknowledge that I have been informed and I understand that:

- Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving, or may in the future receive, from any other licensed health care provider.
- I am at liberty to seek or continue medical care from a physician or surgeon or other qualified health care provider.
- No employee or other practitioner under our clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider.

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- The treatment and therapies rendered or recommended by our clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

_____ (Initials)

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs
- Hospitalization
- Surgery

If you chose to use one of the above noted other treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may worsen your condition. Over time this may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize (*insert your name*) to perform diagnostic tests and render naturopathic therapies and other treatment to my minor son/daughter:_____. This authorization also extends to all other doctors and office staff members and is intended to include laboratory and radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the naturopathic medicine and related treatment. I have discussed it with *(insert your name)* and have had my questions answered to my satisfaction. I understand that it is my responsibility to request the Doctor to explain therapies and procedures to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

Patient's Name: _____ **Doctor's Name:** _____

Signature: _____ **Signature:** _____

Signature of Parent or Guardian (if a minor): _____