Naturopathic Medicine – Informed Consent Form

Naturopathic medicine is the treatment and prevention of diseases by natural remedies. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. The Naturopathic doctor will take a thorough case history and perform a relevant physical exam. It is very important that you inform your Naturopathic doctor of any medical concerns and allergies, as well as any medications and supplements that you are taking.

Please advise the Naturopathic doctor if you are pregnant, suspect you are pregnant or if you are breast-feeding. As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, expected benefits, risks, side effects, and in each case the consequences of not having the diagnosis and/or treatment acted upon. As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine. Some possible side effects could be an aggravation of pre-existing symptoms, an allergic reaction to supplements or herbs, and/or pain, bruising or fainting from acupuncture.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my naturopathic doctor may discuss my case with other healthcare providers associated with the clinic. I understand that I may look at my medical record at any time and that I can request a copy of my file with a fee of $0.15 per page. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Naturopathic doctors to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Naturopathic care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient Name (Please print name): ____

Signature of Patient or Guardian: ____

Date: _________________________

The vision of Townsend Naturopathic Clinic is to provide true integrative medical services. Given our commitment to this best-patient practice, we will communicate with your other medical providers at the clinics to ensure that you are receiving true complimentary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification of this process.

I welcome professional dialogue regarding my case between members of my medical team at Townsend Naturopathic Clinic. **Yes / No**

Signature: ____________________________________

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