**Informed Consent & Use of Personal Information Form**

By consenting to treatment, your naturopathic doctor will have access to your file and personal information. Though gentle, naturopathic therapies have complications associated with certain conditions. It is essentialto be complete in informing your doctor of your current state of physical and mental health, if you are on prescription, over‐the‐counter or recreational drugs, or if you suspect you are pregnant or are currently breastfeeding. As such, your naturopathic doctor will take a thorough case history, perform physical exams, and may request necessary lab work to further assess your case.

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.

There are some minor risks associated with naturopathic therapies which include but are not limited to:

bruising, pain or injury from venipuncture or acupuncture, fainting, organ puncture from acupuncture, aggravation of symptoms with homeopathic remedies, aggravation of pre‐existing symptoms and conditions, allergic reactions to botanicals or supplements, muscle sprains, strains or disc injury from spinal manipulation. The utmost care will be taken to prevent such outcomes.

By signing this document I understand that:

1. I may seek and/or continue to receive medical care from another healthcare provider qualified to practice in Ontario.

2. I am free to withdraw my consent and to discontinue treatment at any time.

3. No one at this clinic is suggesting I refrain from seeking advice from another qualified health care provider.

4. I understand that my Naturopathic Doctor (ND) keeps a record of services provided to me, and

this record is kept confidential, only to be released to others if directed by myself or if required

by law. I may request to see this record at any time and have a copy of this record by paying a

fee.

5. My ND reserves the right to determine if my health concerns fall out of the scope of her practice, in which case an appropriate referral may be recommended.

6. I understand that services at this clinic are not covered by OHIP, and I will be paying for fees at

the time of the appointment; including fees for the visits, prescriptions, services and tests.

7. Therapies recommended to me will be explained in full by my doctor, and that my questions will be answered as best as possible, in a manner which I can comprehend and I have the right to refuse the suggestions.

8. Results are not guaranteed.

9. I do not expect my ND to anticipate all risks and complications, but rely on her to utilize appropriate judgment in my best interests, based on the facts and findings then known.

10. I understand that 24 hours notice is required for visit cancellation or change of appointment, or I will be charged the full cost of a visit.

11. My ND may prescribe medicines or devices, and that I may purchase them from her dispensary, a pharmacy, a health food store, or a medical supply company of my choice.

I acknowledge that I have read and fully understand this consent form and I am free to withdraw my consent and to discontinue treatment at any time.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature if 18yrs or younger:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**