Sacramento Naturopathic Medical Center

INFORMED CONSENT

PATIENT NAME (print) _____

I, (or the patient named above for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the California licensed naturopathic doctor of Sacramento Naturopathic Medical Center and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the doctor, whether signatories to this form or not. I have also read and understand the NOTICE OF PRIVACY PRACTICES (_____) ✍ which discusses my rights under the Health Insurance Portability and Accountability Act of 1996, and the attached OFFICE POLICIES (_____). ✍

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act, which may include but are not limited to nutritional counseling, western herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and IV therapy. I have had the opportunity to discuss with the naturopathic doctor the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I understand that some herbs and supplements may be inappropriate during pregnancy or prior to surgery, and I will immediately notify the doctor if I become aware that I am pregnant or am planning a surgical procedure.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily 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 diagnosis and treatment.

Contact Information: May we leave medically-related information at each location?

Home Phone: _____ ❑ Yes ❑ No

Work Phone: _____ ❑ Yes ❑ No

Mobile Phone: _____ ❑ Yes ❑ No

Email: _____ ❑ Yes ❑ No

Patient Signature_____ Date: _____
(or Patient Representative) Indicate relationship if signing on behalf of patient _____