Active Integrative Medicine

Consent Form for Naturopathic Treatment

Naturopathic medicine is the treatment and prevention of diseases by natural means. A Naturopathic Doctor assesses the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

It is very important therefore that you inform your naturopathic doctor of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your naturopathic doctor immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.

I understand that a record will be kept of my medical history and of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee.

I understand that the results are not guaranteed. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures, except for:

_____

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that it is fully my responsibility to pay Dr. Cecilia Ho, ND for my care at the time of treatment and to confirm with my insurance provider (if applicable) as to coverage for naturopathic care, acupuncture or remedies. (Appropriate receipts will be provided for me to submit, however, Dr. Cecilia Ho, ND is not responsible if I am denied coverage).

☐ I have also read the clinic policy and agree to the terms stated in the clinic policy.

Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____