Naturopathic
Health Center, LLC
415 Howe Avenue Suite 307 Shelton, CT 06484

INFORMED CONSENT FOR TREATMENT

I herby authorize the Naturopathic Health Center, LLC, to perform the following procedures as necessary to facilitate my diagnosis and treatment:

- **Common diagnostic procedures**: e.g., venipuncture, pap smear, radiography, laboratory and x-ray.
- **Physical Examination**: may include but is not limited to the following: skin & dermatology, head, ear, eyes, nose, sinuses & throat, face & neck, lungs & pulmonary, chest & cardiovascular, abdominal, hands, arms & lower limbs, reflexes, motor skills, back and spine, cranial nerves, genitalia, prostate & rectal exams, breast exams, mini-mental status exams, and nutritional exams.
- **Medicinal use of Nutrition**: therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids and other nutritional or therapeutic substances.
- **Botanical Medicine**: botanical substances (herbal medicines) may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters or suppositories.
- **Homeopathic medicine**: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling and hygiene**: diet therapy, fasting, elimination diets, promotion of wellness including recommendations for exercise, sleep, stress reductions and balancing of work and social activities.
- **Minor office procedures**: e.g., dressing a wound, ear cleansing.
- **Naturopathic Physical Medicine**: e.g., muscle stretching/massage, hot and cold therapies, constitutional hydrotherapy, other hydrotherapy treatments.
- Psychological counseling, physical medicine, acupuncture, and bodywork.

The doctors of the Naturopathic Health Center, LLC, have discussed and explained to my satisfaction the basic procedures of the above therapies and the risks and benefits of the care I will receive and I have been given the opportunity to ask questions about the treatment plan and procedures. I recognize certain potential risks and benefits of the procedures I am receiving, as they were described to me and as described more generally below:

Potential Risks: allergic reactions to prescribed herbs and supplements: side effects of natural medications; inconvenience of lifestyle changes; bleeding, bruising or pain with venipuncture; possible prescription drug interaction with prescribed natural supplements or products. Acupuncture may produce temporary numbness, tingling, bruising, bleeding, or redness. Physical medicine may result in temporary pain or discomfort.

Potential Benefits: restoration of health and body's maximal function capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Please read and sign next page

Notice to Pregnant Women: All female patients must inform the practitioner if they know or suspect that they are pregnant as some of the procedures and therapies described above may present a risk to the pregnancy.

Alternatives: I understand that the doctor is not a primary care physician, and the procedures I receive are supplementary care to my primary care physician and/or specialist. It has been recommended to me that I consult with a primary care physician and/or a specialist to obtain information about all of the conventional medicine treatment alternatives available to me.

Confidentiality: I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be release to others unless so directed by my lawful representative, or me or unless law permits or requires it. I understand that my practitioner will answer any questions I have, to the best of his/her ability.

Consent: With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the physician or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I certify that I have read and fully understand this consent and the matters that have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for and on behalf of the below-named patient and that I am signing freely and voluntarily.

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Patient Name (Please Print)

____
Signature of Patient

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Date

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Name of Guardian

____
Signature of Guardian

____
Date

____
Relationship