Kate Smith, N.D.
Josh Canter, N.D., L.Ac.
Danielle Engles, N.D.
Sharon Woodard, N.D.
Prema Health

**Informed Consent and Request for Naturopathic Medical Care**

I, ________________________________, hereby request and consent to examination and treatment with naturopathic medicine with Dr. Kate Smith/Dr. Josh Canter/Dr. Danielle Engles/Dr. Sharon Woodard or other licensed doctors of naturopathic medicine who may serve as substitutes for them in their absence, hereafter called allied health care provider.

I understand that I have the right to ask questions and discuss to my satisfaction with the aforementioned doctors:

(1) my suspected diagnosis(es) or condition(s)

(2) the nature, purpose, goals and potential benefits of the proposed care

(3) the inherent risks, complications, potential hazards or side effects of treatment or procedure

(4) the probability or likelihood of success

(5) reasonable available alternatives to the proposed treatment procedure

(6) potential consequences if treatment or advice is not followed and/ or nothing is done.

I understand that as part of the practice of naturopathic medicine evaluation and treatment may include, but are not limited to:

• Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments) • Common diagnostic procedures (laboratory evaluation of blood, urine, stool and saliva) • Homeopathic remedies (highly diluted quantities of naturally occurring substances) • Dietary advice and therapeutic nutrition (including use of foods, diet plans and nutritional supplements) • Botanical/ herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal

materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, tropical creams, pastes, plasters, washes, or other forms • Hydrotherapy (use of hot and cold water) • Counseling (including but not limited to visualization for improved lifestyle strategies) • Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians) Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression. Potential risks: allergic reaction to prescribed herbs, supplements, aggravation of preexisting symptoms.

Please INITIAL the following:

_______ I understand that my doctor will only prescribe natural therapies and medications if they believe that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.

_______ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.

_______ I understand that these doctors are not psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies.

_______I also understand that it is my responsibility to request that doctors explain therapies and procedures to my satisfaction.

_______I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me.

By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

_____________________________________ Printed name of patient/guardian

_____________________________________ Signature of patient/guardian

____________________________________ Date Signed