



## Declaration and Consent to Treat

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person and treat the cause of the illness by taking into consideration the physical, mental, and emotional aspects of the individual. Gentle, non-invasive techniques are generally used to stimulate the body's inherent healing capacity.

It is very important, therefore, that you fully disclose all information pertaining to medications and over-the-counter drugs you are currently taking, disease processes you are currently suffering from, or if you suspect that you are pregnant.

I acknowledge that I have been informed and I understand that:

1. I have read all the foregoing information and understand that the ultimate responsibility for my health is my own.
2. Dr. Smith is a Naturopathic Doctor, not a Medical Doctor.
3. All treatments offered are within the Naturopathic scope of practice.
4. Any treatment or advice given to me as a patient is not mutually exclusive from any treatment or advice that I may receive now or in the future from another licensed health care provider.
5. I am at liberty to seek or continue medical care from another physician, surgeon, or other health care provider.
6. I accept full responsibility for any fees incurred during care and treatment. I agree to fully discharge this responsibility at the time of the visit unless prior arrangements have been made.
7. As with all medical treatments, Naturopathic treatments may bear certain health risks which include, but are not limited to:
  - a. Allergic reactions to supplements or herbs
  - b. Side effects of medications (ie: hormone therapies, antibiotics)
  - c. Pain, bruising, infection or injury from injections

**Please note: 24-hour cancellation policy – If you will be unable to make your appointment, please notify us 24 hours in advance to ensure you are not charged your visit fee. \_\_\_\_\_ (please initial here)**

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

\_\_\_\_\_  
Patient Signature/Guardian Signature

\_\_\_\_\_  
Date