

INFORMED CONSENT FOR NATUROPATHIC MEDICAL TREATMENT

I hereby authorize and direct Dr. _____, who is a naturopathic physician licensed in the State of Arizona, to do the following:

1. to consult with me about my health concerns, and
2. to run laboratory tests and perform physical exams that we discuss and agree on, and
3. to treat me with naturopathic medicine and/or conventional medicine, as my health condition requires, and as we discuss and agree on over time on a case-by-case basis.

I understand that there may be risks and consequences to my medical treatment, some of which may have never yet been discovered, and that the practice of medicine involves many variables, some of which would be impossible to account for in every situation. There is no medical procedure in which no complication has ever been reported. I understand that it is impossible to guarantee the outcome of any medical procedure, and that I have been given no guarantee as to the results that may be obtained. I understand that the FDA does not necessarily approve of any of these treatments. I further understand that the conventional treatments for cancer are chemotherapy, radiation and surgery. Although my doctor(s) and I will together choose the best treatments for my health condition and goals, I understand that the results and data therefrom will be used anonymously in reporting naturopathic research, as in a case review.

I further understand that Dr. _____ honors the following Patient Bill of Rights. The following list of my rights includes but is not limited to the rights below:

1. I have the right to seek consultation with any physician(s) of my choice, or refuse the same.
2. I have the right to medical treatments from my physician(s) on mutually agreeable terms.
3. I have the right to be treated confidentially, with access to my records limited to those involved in my care or designated by me.
4. I have the right to use my own resources to purchase the care of my choice.
5. I have the right to refuse medical treatment, even if it is recommended by my physician or any other physician, hospital or clinic.
6. I have the right to be informed about my medical condition, and the risks and benefits of treatment and appropriate alternatives.
7. I have the right to refuse third-party interference in my medical care.

Signature of Patient _____

Date: _____

Patient's printed name _____