



### **CONSENT AND AUTHORIZATION FOR TREATMENT**

I, \_\_\_\_\_, hereby **REQUEST AND CONSENT** to receive naturopathic medical care by the Washington licensed naturopathic doctor of Holistic Health Partners and/or other licensed naturopathic doctors who now or in the future may treat me while working or associated with or serving as a back-up for the doctor. I have also read and understand the attached **NOTICE OF PRIVACY PRACTICES** which discusses my rights under the Health Insurance Portability and Accountability Act, and the attached **OFFICE POLICIES**.

The **methods of treatment permitted** by the State of Washington for Naturopathic Doctors may include, but are not limited to:

- Physical exam;
- Common diagnostic procedures;
- Soft tissue manipulation;
- Trigger point injections;
- Nutritional counseling;
- Western herbs;
- Homeopathy;
- Nutritional supplements;
- Oral Chelation;
- Hydrotherapy;
- Intramuscular injections;
- Lifestyle Counseling;
- Contraception;
- Over-the-counter and prescription medications; and
- IV therapy.

The **GOAL OR BENEFIT** of such treatments is to restore health, relieve pain and symptoms of disease, recover from injury or disease, and prevent disease or the progression of disease. The **RISKS OF SUCH TREATMENT** by a naturopathic physician may range from minor to fatal but might include *pain, discomfort, bleeding, blistering, bruising,*

*discolorations, infections, burns, itching, loss of consciousness and deep tissue injury, allergic reaction, or aggravation of pre-existing conditions.*

I understand that ***I HAVE THE RIGHT TO ASK QUESTIONS*** about any topic of concern, but particularly:

- Diagnosis;
- Nature and purpose of the proposed treatment;
- Possible risks and outcomes;
- Skill of the naturopathic physician;
- Alternatives to the proposed treatment or testing;
- Prognosis if the treatment or testing is declined;
- Prognosis if the treatment is undertaken;
- Any conflict of interest on the part of the physician; and
- Identities of substitute physicians who may be called upon to provide treatment or perform testing.

***I have been fully informed by Dr. Schloss or Dr. Colston as to the benefits, risks and possible consequences involved in treatment by a Naturopathic Physician.*** I have had the opportunity to discuss with the naturopathic doctor the nature and purpose of naturopathic treatments and procedures. *I understand there are differences between the treatments provided by a Naturopathic Physician and those of traditional medical providers and have made the voluntary decision to address my health concerns through Naturopathic treatments.* I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk.

I have been advised that many of the assessments, treatments and approaches used in this office are not endorsed nor approved by either the FDA (Federal Drug Administration), the AMA (American Medical Association) or any other governing or legislative body.

The herbs, homeopathic medicines and nutritional supplements that have been or may be recommended are generally considered safe when taken as instructed in the practice of naturopathic medicine. However, as with any use of medication, there may be risks and the safety is dependent upon full communication to the naturopathic physician of any health concerns as well as my use of the herbs, supplements and/or medications only as prescribed or instructed. ***I AGREE TO NOTIFY MY NATUROPATHIC PROVIDER IMMEDIATELY IF I HAVE CHANGES IN MY HEALTH CONDITION OR ADVERSE REACTIONS, BECOME PREGNANT, HAVE A BLEEDING DISORDER, PACE MAKER, CANCER, OR PLAN TO UNDERGO SURGERY, AS SUCH TREATMENTS MAY NOT BE SAFE UNDER THOSE CIRCUMSTANCES.***

***NOTICE TO PREGNANT WOMEN:*** All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy.

I understand that, as with all medical treatments, there is no guarantee that it will provide resolution for my medical conditions or prevention of future injury or disease.

I have read and agree with the above statements, and voluntarily provide my consent to treatment and diagnostic procedures as recommended by the naturopathic physician. I understand I can withdraw my consent at any time.

DATED this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

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Signature of patient or person authorized to consent for patient

*Holistic Health Partners LLC  
Wendy A. Schloss, ND and Letitia L. Colston, ND*