

**INFORMED CONSENT TO NATUROPATHIC TREATMENTS**

**(Must be signed prior to first appointment)**

**Dr. Caitlin Shea, N.D.**

Naturopathic medicine is the prevention and treatment of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are used to stimulate the body’s inherent healing capacity. The naturopathic doctor will take a thorough case history, and do a physical exam if necessary. It is important that you inform the naturopathic doctor of any disease process that you are suffering from, and any medications (prescription or over-the-counter) that you are currently taking. Please advise your naturopathic doctor if you are pregnant, suspect you are pregnant, or if you are breastfeeding.

As a patient, you will receive information about your diagnosis, and/or treatment, courses of action, the effects, expected benefits, risks, side-effects, and in each case the consequence of not having the diagnosis and/or treatment acted upon. There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

• Some patients may experience allergic reactions to certain supplements and herbs. Please advise your naturopathic doctor of any allergies you may have.

• Pain, bruising or injury from acupuncture.

• Fainting or puncturing of an organ with acupuncture needles.

During the course of your treatment, some form of products (vitamins, herbs, nutritional supplements) may be suggested as part of your treatment. Please be informed that it is your choice to purchase these products directly from the naturopathic doctor, or from another supplier.

 I understand:

• The naturopathic doctor does not guarantee treatment results.

• The naturopathic doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.

• I am free to withdraw my consent and to discontinue treatment at any time.

• I understand the full meaning of the consent form and its consequence.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that the naturopathic doctor may discuss my case with other healthcare providers. I understand my medical record may be written and stored electronically on external, encrypted servers. This medical record complies with the legal requirements for all medical records in the province of Ontario.

Patient Name (Please Print)

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Signature of Patient or Guardian

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

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_