



Balanced Family

NATURAL MEDICINE

Informed Consent and Request for Naturopathic Medical Care

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Lara Martin, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Naturopathic Medicine with Dr. Lara Martin and/or other licensed doctors of naturopathic medicine serving as backup for her, hereafter called *allied health care provider*.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Lara Martin, and/ or with the *allied health care provider* providing backup:

- (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 a Naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intramuscular vitamin injections)
- 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, topical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- 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)

Please INITIAL the following:

_____ I understand that Dr. Lara Martin is not licensed to prescribe any controlled substances.

_____ I understand that Dr. Lara Martin, will only prescribe medications if she believes that they are in the best interest of myself, the patient.

_____ 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 Dr. Lara Martin is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Lara Martin, and/or any *allied health care provider* to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request Dr. Lara Martin 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

Signature of Patient

Date

Printed Name of Guardian

Signature of Guardian

Date