



## Informed Consent to Treat

Welcome to my naturopathic practice. As a naturopathic doctor, I consider you as a whole person, taking into consideration physical, mental, emotional and spiritual aspects of your case. In my practice, I use a variety of naturopathic approaches to stimulate your body's inherent healing capacity and assist you to restore your health.

### What to Expect

During your first visit, I will take a thorough case history and perform a physical examination. If your case requires, the physical may include more specific examinations such as breast, gynecological, rectal, prostate or genital exams. Blood and urine samples may also be required for diagnostic and monitoring purposes. Treatment options will be discussed and recommendations will be made after thorough evaluation and assessment of case history and physical exam information. All tests, specific examinations, and treatments will only be performed after explaining the purpose and procedure as well as recommending alternate options. A number of different approaches may be used through the course of treatment to support your natural ability to heal.

### Treatment Risks

Even the gentlest therapies may potentially cause unexpected reactions because of the range in such factors as age, genetic variation, pre-existing conditions, medications, environmental sensitivities, etc. It is very important that you inform your naturopathic doctor immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise your naturopathic doctor immediately if you are pregnant, suspect you are pregnant, or if you are breast-feeding.

There are some health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to certain supplements and/or herbs
- Pain, fainting, bruising or injury from acupuncture
- Accidental burning of the skin from the use of moxa
- Muscle strains and sprains
- Disc injuries from spinal manipulation

## Statement of Acknowledgement

I, \_\_\_\_\_ (*Print patient name*), understand and am informed that, as in the practice of other medicine, there are some risks to naturopathic therapies. The information I have provided is complete and inclusive of all health concerns, including the possibility of pregnancy, and all medications I am taking, including over-the-counter drugs and supplements. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I accept full responsibility for any fees incurred during care and understand that payment is due at the time of service.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private or public agency attempting to gather information without so stating.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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Signature

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Witness

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Date

## Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important part of our clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic is doing to ensure that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopaths (BDDT-N)

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your information.

This clinic will collect, use and disclose information about you for the following purposes:

To assess your health concerns	To advise you of treatment options
To provide health care	To establish and maintain contact with you
To distribute health care information to you	To book and confirm appointments
To communicate with other treating health-care providers	To allow us to efficiently follow-up for treatment, care and billing
For teaching and demonstrating purposes on an anonymous basis	To invoice for goods and services
To complete claims for insurance purposes	To process credit card payments
To collect unpaid accounts	To comply generally with the law
To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale	To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy (BDDT-N)

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above. If new purposes arise, we will seek your approval in advance.

## Patient Consent

I have reviewed the above information that explains how the naturopathic doctor will use my personal information, and the steps the clinic is taking to protect my information. I agree that Cyndi Gilbert, ND can collect, use and disclose personal information about \_\_\_\_\_ as set out above in the information about the clinic’s privacy policies. (Print patient name)

\_\_\_\_\_  
Print name of patient or guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date