Informed Consent to Treatment

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It is important to notify Dr. Elizabeth Yaworsky, ND immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs, supplements, or herbal preparations
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant, or you are breast-feeding

There are some slight health risks possible with some Naturopathic medical treatments, which will be discussed with you in detail before any specific treatment is initiated. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or botanicals
- Pain, bruising, infection or injury from acupuncture or cupping
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains, disc injuries from spinal manipulation

I, _____, understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself when law requires it. I understand that I may look at my medical record at anytime, and can request a copy of it, or have a report drawn up by paying the appropriate fee, which will be kept confidential.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Doctor to exercise judgement during the course of the procedure, which she feels at that time is in my best interests, based on the facts known to her. With this knowledge, I voluntarily consent to naturopathic diagnostic and therapeutic procedures.

I intend this consent form to cover the entire course of treatment for my health condition I am seeking treatment for. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I DECLARE that I have received a full and complete explanation of the treatment of services that I may receive with my Naturopathic Doctor and hereby authorize and consent to treatment.

Patient's Full Name (Please Print): _____

Date of Consent: _____

Signature of Patient (or Parent/Legal Guardian):_____

Naturopathic Doctor: Dr. Elizabeth Yaworsky, ND_____