CONNECTICUT CENTER FOR NATURAL HEALTH, PLLC.

Naturopathic Medicine ♦ 860-347-8600

INFORMED CONSENT FOR TREATMENT

Name: _____

I hereby authorize the Naturopathic physicians and other practitioners of the CT Center for Natural Health, PLLC to perform the following specific procedure(s) as necessary to facilitate my diagnosis and treatment:

- **Common diagnostic procedures:** e.g., venipuncture, Pap smears, radiography, laboratory, and x-ray.
- **Minor office procedures:** e.g., dressing a wound, ear cleansing.
- **Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids and other nutritional or therapeutic substances.
- **Botanical medicine:** botanical substances (herbal medicines) may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling and hygiene:** diet therapy, fasting, elimination diets, promotion of wellness including recommendations for exercise, sleep, stress reductions and balancing of work and social activities.
- **Psychological counseling.**
- **Physical Medicine, acupuncture and bodywork.**

Practitioners of CT Center for Natural Health, PLLC have discussed and explained to my satisfaction the basic procedures of the above therapies and the risks and benefits of the care I will receive and I have been given the opportunity to ask questions about the treatment plan and procedures. I recognize certain potential risks and benefits of the procedures I am receiving, as they were described to me and as described more generally below:

POTENTIAL RISKS: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, venipuncture for diagnostic testing, and possible prescription drug interaction with prescribed natural supplements or products. Acupuncture may produce temporary numbness, tingling, bruising or redness.

POTENTIAL BENEFITS: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

ALTERNATIVES – I understand that the practitioners at the CT Center For Natural Health, PLLC are not primary care physicians, and the procedures that I will receive at the CT Center For Natural Health, PLLC are supplementary care to my primary care physician and/or specialist. It has been recommended to me that I consult with a primary care physician and/or a specialist to obtain information about all of the conventional medicine treatment alternatives available to me.

NOTICE TO PREGNANT WOMEN - All female patients must inform the treating doctor if they know or suspect that they are pregnant as some of the procedures and therapies described above may present a risk to the pregnancy.

CONSENT - With this knowledge, I voluntarily consent to the above procedure(s), realizing that no guarantees or warrantees have been given to me by the CT Center for Natural Health, PLLC or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

TEACHING CLINIC - I understand that the CT Center for Natural Health, PLLC often participates as a teaching clinic, and that faculty and students may observe or participate in the care provided, and that my case may be discussed (without identifying information) for educational purposes.

TELE-MEDICINE – I understand that the CT Center for Natural Health, PLLC may use a secure format of tele-medicine to communicate with me regarding my health and/or treatment thereof.

CONFIDENTIALITY - 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 my lawful representative, or me or unless law permits or requires it. I understand that I may request to view my medical record and can request a copy of it by paying the appropriate copying fee.

I understand that my medical record will be kept for a minimum of seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner will answer any questions I have, to the best of his/her ability.

I certify that I have read and fully understand this consent and the matters, which have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for an on behalf of the above-named patient and that I am signing freely and voluntarily.

_____ _____

Date Signature of Patient

_____

Signature of Patient Representative or Guardian