Good News Naturopathic Clinic
83 East Ave STE 209, Norwalk CT 06851
203-450-6463(Tel) 203-900-8747(Fax)

INFORMED CONSENT TO TREAT

I, ____________________________, voluntarily request and authorize Good News Naturopathic Clinic (GNNC) to provide naturopathic medical treatment to __________________________.
(SELF/CHILD)

I authorize Good News Naturopathic Clinic to perform the following procedures, as necessary and appropriate, to adequately diagnose and/or treat my condition(s):

- Common diagnostic procedures: e.g. venipuncture, radiography, laboratory and X-ray.
- Medical 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..
- 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.
- Minor office procedures: e.g. dressing a wound, ear cleansing.
- Psychological counseling, physical medicine, acupuncture and bodywork.

Good News Naturopathic Clinic (GNNC) has 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 described more generally below:

Potential Risks: allergic reactions to prescribed herbs and supplements; side effects of natural medications; inconvenience of lifestyle changes; bleeding, bruising or pain with venipuncture; possible prescription drug reaction with prescribed natural supplements or products. Acupuncture may produce temporary numbness, tingling, bruising, bleeding or redness. Physical Medicine may result in temporary pain or discomfort.

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

Notice to Pregnant Women: All female patients must inform GNNC if they know or suspect they are pregnant as some procedures and therapies described herein may present a risk to the pregnancy.

Alternatives: I understand that Good News Naturopathic Clinic (GNNC) is not a primary care physician, and the procedures I will receive in this office 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. If I am currently taking prescription medication, GNNC has strongly advised me to consult with the prescribing physician to address any concerns. GNNC has not recommended or advocated that I discontinue use of my prescribed medication. I acknowledge that should I decide to discontinue my medication without proper consultation, I assume full responsibility and liability for any and all occurrences resulting from such actions.
Patient Initials: ________

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 my request to view or receive a copy of my medical record can only be done with a signed form of records release obtainable at Good News Naturopathic Clinic.

I acknowledge GNNC has not made any guarantees regarding amelioration of current or future health conditions with the use naturopathic medicine. I fully understand GNNC cannot anticipate risks or complications, and therefore authorize GNNC, exercising sound judgement, to do what is in my best interest should such circumstances arise.

I acknowledge that I have read this form in its entirety and am in full agreement with the content. I have been given the opportunity to ask questions and GNNC has reviewed and adequately addressed all of my questions and/or concerns. I formally consent to the services to be rendered by GNNC and understand this consent will cover the entire course of treatment for present and future conditions for which I seek treatment. I may terminate this consent at any time by providing written request to GNNC without consequence or compromise in care.

Patient Signature: ______________________________ Date: __________________

Print Name: __________________________________

Parent or legal guardian must sign on behalf of minors.

Parent/Guardian Signature: ________________________ Date: __________________

Print Parent/Guardian Name: ______________________