

Informed Consent to Naturopathic Care

This consent form applies to the patients of Dr. Kelly Wallace, N.D. at the Wallace Integrated Health Centre, in North Bay, and at Action Potential, in Sturgeon Falls.

By consenting to treatment, you are authorizing your N.D. to keep a record of your personal information and the services provided to you. This record will be kept confidential and will not be released to others unless so directed by yourself, or unless required by law. You may specifically request that your file be accessible to another professional at the Wallace Integrated Health Centre, if they are also providing treatment to you.

Even the gentlest therapies can have complications in certain cases (i.e. pregnancy, lactation, multiple drug use, immuno-compromised patients) and some therapies must be used with caution. It is very important that you are completely forthright in informing your N.D. of any health conditions, prescription or over the counter medications. If you are pregnant, suspect you may be pregnant or are breastfeeding, please notify your N.D. immediately.

There are some slight health risks associated with Naturopathic medical care. They include, but are not limited to:

- Aggravation of pre-existing conditions or symptoms
- Allergic or adverse reactions to supplements or botanical prescriptions
- Pain, fainting, bruising, injury or burning from acupuncture or moxa

Consent

I understand that my medical record will be kept confidential, in accordance with current government privacy policy. I understand that I may look at my own medical record at any time, and may request a copy of it by paying the appropriate fee. I understand that I must pay for all tests, in-office prescriptions and services when rendered. I understand that my identity will be protected and kept confidential.

I understand that my N.D. will answer any questions that I have to the best of her ability, in a manner that I can comprehend. I understand that results are not guaranteed. I will rely on my N.D. to exercise the best judgement for my treatment, in my best interest, based on the facts and findings then known. I do not expect my N.D. to be able to anticipate all risks and complications. With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures that my N.D. suggests.

I intend for this consent to cover the entire course of treatment presented for my present condition. I understand that I am free to withdraw my consent, verbally or in written form, at any time. I indicate my willingness to participate by releasing Kelly Wallace, N.D. and the Wallace Integrated Health Centre and Action Potential from claims, causes of action and all liabilities in connection with any unlikely potential negative effects, from myself, my heirs and executors.

(signature)

(date)

(parental signature, if under 18)

(date)

****If receiving treatment from another professional at the Wallace Integrated Health Centre, or Action Potential**

I give consent for _____ (specify name of professional), to access my naturopathic file, so that they may be better able to provide treatment for me, within their own scope of practice.

(signature)

(date)