

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.

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.

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 my identity will be protected and kept confidential.

I understand that I must pay for all appointments, tests, in-office prescriptions and other services when rendered. I understand that there is a fee of \$25 for any missed appointments, without proper notification.

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 on the understanding that all suggested treatments, possible adverse effects and anticipated benefits will be fully explained by my N.D. I understand that I am free to withdraw my consent 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)