Wallace
Integrated Health Centre

Dr. Kelly Wallace, B.Sc., N.D.

Informed Consent to Naturopathic Care

By consenting to treatment, you are authorizing your N.D. to keep a record of your personal health 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 required by law.

Even the gentlest therapies can have complications in certain cases. Therefore, 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 (Please initial each paragraph)

I understand that my medical record will be kept confidential, in accordance with current Ontario government privacy policy. I understand that I may request a copy of my medical record 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 consent to pay the appropriate fee for any appointments missed or cancelled without proper notification. These fees are posted in the front office. _____

I declare that I am seeking treatment for my personal health only, and am not an agent of any private, local, provincial or federal organization attempting to gather information without so stating._____

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, anticipated benefits, alternate treatment options and costs will be fully explained by my N.D. I understand that I am free to decline any part of the treatment plan at any time and to withdraw my consent and discontinue treatment 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)

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