Wallace Integrated Health Centre

Kelly Wallace, N.D.

Informed Consent to Treatment – Flu Clinic (FAMILY)

Name:__________________________ Address:__________________________
Phone Number:___________________ __________________________________
Email:__________________________ __________________________________
Date of Birth:____________________ Age:______________________________

Do you have any of the following conditions?

Diabetes
Daisy allergy
Iodine allergy
Tuberculosis
Leukemia
Autoimmune disease (Lupus, Scleroderma…)
Multiple sclerosis
HIV/AIDS
Chronic viral disease

This consent form applies to clients receiving the homeopathic alternative to the flu shot from the Kelly Wallace, Naturopathic Doctor (N.D.) at the Wallace Integrated Health Centre. I understand that my N.D. keeps a record of the services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or unless the law requires it. I understand that I must pay for all services when rendered. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my N.D. will answer all questions that I have, to the best of her ability, in a manner which I can comprehend. I understand that results are not guaranteed with the homeopathic alternative to the flu shot. I understand that there are some slight risks associated with homeopathic treatments, which may include, but are not limited to the aggravation of pre-existing symptoms. I will rely on my N.D. to exercise the best judgement in my interests, based on the facts and findings then known. With this knowledge, I voluntarily consent to the therapeutic procedure mentioned above. I indicate my willingness to participate by releasing Kelly Wallace, N.D. and the Wallace Integrated Health Centre from claims, causes of action and all liabilities in connection with any unlikely potential negative effects, from myself, my heirs and executors.

I intend for this consent to cover the homeopathic alternative to the flu shot for myself and my family members listed below. I understand that I am free to withdraw my consent and discontinue my participation at any time.

Client signature:__________________________ Date:_____________________

Signature of N.D.:_________________________ Reg. #:___________________

Would you like a reminder for next year by phone or email ?

Other Family Members	Birth Date/Age	Please list any health concerns on above list

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