

Consent To Naturopathic Treatment at Energy Health Clinic

Date: _____

Patient Name: _____ Date of Birth: _____

I voluntarily consent to outpatient care Energy Health Clinic, encompassing routine diagnostic procedures, examination and naturopathic medical treatment (within the scope of practice as determined by the CNPBC), and administration of medications prescribed by the naturopathic doctor.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.

Please initial in spaces below

_____ 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 without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____ I understand that the Naturopathic Doctor will answer any question that I have to the best of her ability. I understand that the results are not guaranteed. The Doctor will explain, to the best of her ability risks of each treatment, however she is not able to anticipate all risks or complications of treatments provided.

_____ I understand that charges are to be paid at the time of the visit unless specific arrangements have been made **prior** to my scheduled appointment. Payment for all dispensary items is due at the time of the visit.

_____ I understand that a fee will be charged (Missed Appointment Fee) for any missed appointment or late cancellations (less than 24 hours).

_____ I understand that this consent form will be valid and remain in effect as long as I receive medical care at Energy Health Clinic.

This form has been explained to me and I fully understand this *Consent To Treatment* and agree to its contents.

If the patient is a **minor**, please complete the following:

- Patient is a minor and is _____ years of age

Name of legal guardian _____ Signature of legal guardian _____

Signature of Patient: _____