true health
MEDICINE, PC

Promoting true health and healing.

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Informed Consent for Treatment

I, _____, hereby authorize the doctors of True Health Medicine, P.C., to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **Common diagnostic procedures:** e.g., venipuncture, UA, Pap smears, radiography, laboratory.
- **Minor office procedures:** e.g., ear cleansing.
- **Naturopathic physical medicine:** e.g. craniosacral technique, muscle energy stretching, therapeutic massage techniques, heat and cold therapies, electric stimulation, manual therapies and other related treatments.
- **Medical use of nutrition:** therapeutic nutrition, nutritional supplementation, intramuscular vitamin injections.
- **Western Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, gels, or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling:** promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work, spiritual awareness, and social activities.

I recognize the potential risks and benefits of these procedures as described below:

- **Potential risks:** allergic reactions to prescribed herbs and supplements; side effects of natural medicines; inconvenience of lifestyle changes; injury from injections, venipuncture, or physical medicine.
- **Potential benefits:** restoration of health and the body's maximal capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
- **Notice to Pregnant Women:** All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

Patient Signature:_____ Date:_____