INFORMED CONSENT FOR NATUROPATHIC TREATMENT

I consent to being treated at Origin Health Center. I understand that my care as a patient at the OHC is directed by licensed naturopathic doctors. I authorize the doctors at OHC to perform the following procedures to facilitate my diagnosis and treatment:

1. **Common diagnostic procedures** – venipuncture, pap smears, radiography, laboratory, and x-ray
2. **Botanical medicine** – herbal substances may be prescribed as tea, alcoholic tinctures, capsules, tablets, powder, creams, plasters, salves, and suppositories
3. **Hydrotherapy** – the thermal/mechanical effects of water
4. **Homeopathy** – the use of highly diluted quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses
5. **Therapeutic nutrition** – vitamins, minerals, amino acids, and other nutritional substances
6. **Energy Medicine** - use of therapeutic gemstones
7. **Environmental Medicine** – IVs, detox procedures
8. **Naturopathic Aesthetics** – PRP, facials
9. **Lifestyle counseling** – diet therapy, fasting elimination diets, promotion of wellness including recommendations for exercise, sleep, stress reduction, balance of work and social activities.

I fully understand the benefits and risks of these procedures:

1. **Potential benefits** – restore and improve health, prevention of diseases, pain relief, aging well, better diet and lifestyle, more energy
2. **Potential risks** – adverse reactions herbs and supplements, interaction with certain pharmaceuticals, aggravation of pre-existing conditions, pain, no improvement of symptoms
3. **Notice to pregnant women –** all female patients must inform the treating doctor if they know or suspect that they are pregnant as some of the procedures and therapies described above may present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, acknowledging that no guarantees have been given to me by Origin Health Center or any of its personnel regarding cure or improvement. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of procedure and treatment, that is based on the information known at the time and is in my best interest. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. 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 unless so directed by my representative or me or otherwise permitted or required by law.

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Patient's Name	Patient's Signature	Date

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Guardian/Personal Representative's Name	Signature	Date