TARA ANCHEL, ND
NATUROPATHIC DOCTOR

Informed Consent

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches are employed including diet and nutritional supplements, botanical medicine, homeopathy, Asian medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counselling.

On your first appointment, a thorough history will be taken and a physical examination will be performed. Because some naturopathic therapies must be used with caution with patients experiencing particular conditions (such as pregnancy and lactation, kidney disease and heart disease), it is very important that you inform your ND immediately about any disease process you are suffering from, as well as any form of medication, drug or supplement you are taking.

There are some slight health risks to treatment by Naturopathic Medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms,
- Allergic reactions to supplements or herbs,
- Pain, bruising or injury from venipuncture or acupuncture,
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.

_____ I understand that a record will be kept of the health services provided to me, that it will be kept confidential and will not be released to others unless so directed by myself unless the law requires it.

_____ I understand that I may look at my medical record at anytime, and can request a copy of it by paying the appropriate fee.

_____ I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

_____ I understand that the practitioner will answer any questions that I may have to the best of her ability.

_____ I understand that results cannot be guaranteed.

_____ I do not expect the ND to be able to anticipate and explain all risks and complications.

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_____ I understand that I am at liberty to seek or continue to seek medical care from other health care providers who are qualified to practice in Ontario.

_____ With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

_____ I intend this consent form to cover the entire course of treatment for my present condition.

_____ I understand that I am free to withdraw my consent and to discontinue my participation in these procedures at any time.

_____ I understand that fees and supplements are to be paid for at the time of consultation, and that a missed appointment fee will be charged for any missed appointments or cancellations with less than 24 hours notice.

Patient Name: _____(Please Print)

Signature of Patient (or Guardian): _____

Date: _____ Care Provider: _____

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