INTEGRATIVE HEALTH INSTITUTE

Good health enables empowered, authentic living.

Naturopathic Medicine - Pediatric Informed Consent

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Your ND will take a thorough case history and perform a relevant physical examination. It is very important that you inform your naturopathic doctor of any medical concerns or medication and supplements you may be taking. Please advise your ND if you are pregnant, suspect you are pregnant or if you are breast-feeding. As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine including acupuncture. By initialing next to each statement, you acknowledge your understanding of the associated risk and grant permission to proceed. Possible side effects of naturopathic medical care include:

- Aggravation of pre-existing symptoms ____
- Allergic reactions to supplements or herbs ____
- Pain, bruising or injury from acupuncture ____
- Fainting or puncturing of an organ with acupuncture needles ____

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my naturopathic doctor may discuss my case with other healthcare providers. I understand that I may look at my medical record at anytime and can request a copy of my file with a fee of $0.10 per page. 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 results are not guaranteed. I do not expect the naturopathic doctors to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Naturopathic care I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient Name: (Please print name):_____

Signature of Patient or Guardian:_____ Date:_____

Naturopathic Doctor: _____ ND Signature: _____

The vision of the Integrative Health Institute is to provide true integrative medical services. Given our commitment to this best-patient practice, we will communicate with your other medical providers at the clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.

I welcome professional dialogue regarding my case between members of my medical team at the Integrative Health Institute: Yes I No

Signature: _____

Integrative Health Institute
46 Sherbourne Street, 2nd Floor I Toronto ON I M5A2P7 I 416.260.6038

INTEGRATIVE HEALTH INSTITUTE

Credit Card on File:
Billing Authorization Form

Client's Name: _____

Name as it Appears on the Credit Card: _____

Type of Credit Card: MasterCard I Visa

CardNumber:_____

Expiration Date: (month/year) _____

Security Code: (last 3 numbers on back of card) _____

I, _____ authorize Integrative Health Institute to process the above credit card as "Signature on File" for any balance due on my account.

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Cardholder's Signature Date

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