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Naturopathic Medicine
Informed Consent for Treatment

I, _____ , hereby authorize Dr. Chad Aschtgen, in accordance with the scope of his practice, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Botanical Medicine: botanical substances may be prescribed as loose teas, alcohol tinctures, capsules, tablets, creams, suppositories, etc.
Common Diagnostic Procedures: venipuncture, Pap smears, radiography, laboratory, x-ray, ultrasound, etc.
Contraception: family planning, education, oral contraceptives, barrier devices, IUDs, etc.
Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plant, animal and mineral substances to gently stimulate the body's innate healing responses.
Intravenous Therapies: including high dose vitamin, mineral, botanical and other nutrients.
Immunization Therapies
Lifestyle Counseling and Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Medical Nutrition: therapeutic nutrition, nutritional supplementation and intramuscular vitamin injections.
Minor Office Procedures: wound dressing, ear cleansing, sutures, biopsies, etc.
Naturopathic Manipulation: osseous and tissues adjustments manually or by instrument assisted techniques.
Physical Medicine: massage, stretching, exercises, mobilizations, contrast water or heat/cold applications.
Psychological Counseling: improved lifestyle strategies and wellness, not including the specific treatment of mental illness.

I recognize that I have a right to be informed about my condition and recommended care. This waiver is to help me become better informed so I may give, or withhold, my consent after having an opportunity to discuss my condition, potential benefits, risks, side effects and hazards involved, likelihood of success, alternative treatment options and potential consequences if treatment or advise is not followed and/or nothing is done.

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

Potential Risks: allergic reactions to prescribed herbs and/or supplements, side effects of natural medications, adverse interactions with other drugs, herbs and/or nutrients, inconvenience of lifestyle changes, injury from injections, venipuncture or other procedures.

Potential Benefits: restoration of health and the body's maximal functional capacity, relief of pain and certain symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its further 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, acknowledging that no expressed or implied guarantees have been made to me by Dr. Aschtgen or any affiliate physician or staff regarding cure or improvement of my condition. I also realize that my practitioner(s) cannot anticipate and explain *every* possible risk or complication, and I wish to rely on the practitioner to exercise judgment during any of the above procedures and in recommending dietary supplements and any other treatments for my condition(s). By signing below, I acknowledge that I have been provided ample opportunity to read, or have been read, this form and have had any questions satisfactorily

answered. I agree to use this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment. I also understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that Dr. Aschtgen from time to time offers preceptorships to medical students and resident physicians who may observe or participate in the care provided and I have the right to decline their presence during my visit, procedure or treatment at any time. I understand that medical students, residents and office staff are subject to, and will abide by, the privacy policies of which I have been provided or declined a copy.

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 myself, or my representative, as may be required by law or as necessary for insurance claim processing reasons. I understand that I may review my medical record at any time and may also request a copy. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. 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 any questions I have will be addressed to and answered by Dr. Aschtgen to the best of his ability.

Print Patient's Name	*Patient's Signature* *Date*
Print Name of Guardian or Responsible Party	*Signature of Guardian/Responsible Party* *Date*