

Informed Consent and Request for Care (Naturopathic)

As a patient, I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Amalia Treadwell, ND/LAc, Dr. Ashlie Hempstead ND/LAc, Dr. Clara Fashana ND/LAc, Dr. Ilana Gurevich ND/LAc, Dr. Rebecca Principe ND, Dr. Natalie Hanan ND/LAc, Dr. Kathryn Kloos ND/ LMT having had the opportunity to discuss the potential benefits, risks, and hazards involved.

I, _____, hereby request and consent to examination and treatment with the above-mentioned provider.

I understand that I have the right to ask questions and discuss my case, to my satisfaction, with the above-mentioned provider and/or with the backup allied health care provider at **Kwan Yin Healing Arts Center East**. This information may include, but is not limited to:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of the treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done

Naturopathic Evaluation Information:

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic, and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory)
- Evaluation of blood, urine, stool, and saliva
- Soft tissue and osseous (bone) manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage [to relieve muscular discomfort associated with pregnancy], muscle energy technique, CranioSacral therapy, and Visceral Manipulation)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements, and intra-muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- Botanical/herbal medicines, prescribing of various therapeutic substances (including plant, mineral, and animal materials). Substances may be given in the forms of teas, pills, creams, powders, and/or tinctures, which may contain alcohol, suppositories, topical creams, pastes, plasters, washes or other forms.
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, which may include transcutaneous electrode stimulation)
- Counseling (including, but not limited to, visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians)

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Potential Benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential Risks: Pain, discomfort, blistering, minor bruising, discoloration of skin, infections, burns, or itching; Loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs or supplements; Soft tissue or bony injury from physical manipulations; Aggravation of pre-existing symptoms.

Notice to Pregnant Women: All female patients must alert the provider if they have confirmed or suspected pregnancy, as some of the therapies prescribed could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. Any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to Individuals with: bleeding disorders, pace makers and/or cancer: For your safety, it is vital to alert your healthcare provider of these conditions.

Please INITIAL the following:

_____ I understand that the above-mentioned provider(s) are not licensed to prescribe any controlled substances.

_____ I understand that the above-mentioned provider(s) will only prescribe medications if they believe that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescription medication needs.

_____ I understand that the US Food and Drug Administration has not approved nutritional, herbal, and homeopathic substances, however, these have been used widely in Europe, China, and the USA for years.

_____ I understand that the above-mentioned provider(s) is not a psychologist or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect the above-mentioned provider(s) and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the above-mentioned provider(s) explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services has been made to me concerning the results intended from any treatment provided to me. By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Printed Name of Patient	Signature of Patient	Date
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Printed Name of Guardian/Guarantor	Signature of Guardian/ Guarantor	Date
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