

Informed Consent for Treatment

I _____, hereby authorize the private practitioner to perform the following specific procedures as necessary to facilitate my diagnosis and treatment.

Diagnostic Procedures: blood draw, Pap smears, laboratory tests, x-ray

Medicinal Use of Nutrition: therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids, plant products; All of which may be administered orally, topically, intramuscularly, or internally.

Botanical Medicine: Plant derived medicines applied or taken as creams, plasters, pastes, suppositories, teas, tinctures, capsules, and solid extracts.

Lifestyle Counseling and Hygiene: Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, balance in work and social activity.

Homeopathic Medicine: Prescription of extremely dilute mixtures of plant, mineral, or animal based substances in order to re-establish homeostasis.

Inner Healing Prayer: Prayer to facilitate restoration of the mind, will, and emotions through the conscious seeking of forgiveness, giving forgiveness from the will, the mind and then the emotions. Repentance and being forgiven.

Minor Surgery: Excess earwax removal and cleaning, wound dressing, etc...

I recognize the potential risks and benefits of these methods, treatments, and procedures as described below.

Potential risks; Allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from needles, either injections or blood draw.

Potential benefits: Restoration of health, relief of pain and symptoms of disease, assistance in disease and injury recovery, prevention of disease or its progression, less reliance on medications and prescription drugs, increased energy, improved mood, and wellness.

Notice to Pregnant Women: All female patients must disclose their pregnant status or suspected pregnancy. Some therapies may present a risk to the mother or developing baby. Having read and understood the disclosures above, I voluntarily consent to the above procedures, and do recognize that no guarantee has been given to me by the physician regarding improvement or cure of my medical and health conditions. I understand that I am free to withdraw my consent and to discontinue evaluation and treatment 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 requested by myself, or my representative, or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying a nominal fee. I understand that my medical record will be kept for a minimum of three, but not 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 my practitioner will answer any questions I have to the best of his ability.

Patient Signature _____ Date _____

Guardian, Representative _____ Date _____

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