# INFORMED CONSENT TO NATUROPATHIC DIAGNOSTIC / THERAPEUTIC PROCEDURES

Patient Name ______________________________ Phone No. ________________________

Address ____________________________City/Town_________________________________

Each person seeking care in this clinic should understand that the practitioner is a naturopathic doctor, not a medical doctor. Naturopathy uses non-invasive methods for the assessment of disease and natural therapies for correction. The methods used in this clinic for assessment include physical examination, body impedance analysis, blood work, stool analysis or salivary analysis. Methods for therapeutics can include nutrition, botanical medicine, lifestyle changes, homeopathy, detoxification techniques, intravenous therapy, or acupuncture.

Each person must sign this document before any treatment will be rendered. My signature acknowledges that:

**1.** I have been informed of and I understand that

**a)** the treatment received at this office may be different than that usually offered by a medical doctor or other licensed health care providers

**b)** I am at liberty to seek or continue to seek medical care from a physician or surgeon or other health care provider qualified to practice in Ontario

**c)** I confirm that **Tara Clapp, ND** nor anyone else in this office has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider in matters of treatment for myself (or my child).

**2.** I declare that I have received a full and complete explanation of the treatment or services that I (or my child) may receive at this office and hereby authorize and consent to treatment.

**3.** I agree to pay my (or my child's) account in full at the time of each visit or treatment, including fees for services, costs of laboratory tests and any other fees incurred during his/her visit. I am aware that these fees are not covered by OHIP.

## RECOMMENDED DIAGNOSTIC / THERAPEUTIC PROCEDURE(S)

(including those by referral to another practitioner)

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I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic/ therapeutic procedure(s) described above and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the procedure(s) with respect to the nature of the procedure, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I understand that I can withdraw my consent.

____________________________________ ____________________________

**Patient or Lawful Representative Signature** **Date Signed**

____________________________________ ____________________________

**Witness Signature** **Witness Relation to Patient**

**Tara Clapp N.D.**
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