



## Informed Consent for Treatment

This form is part of our effort to inform you about your diagnosis and/or treatment options, 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. Please read it carefully.

Your physicians at the Alpine Valley Wellness Center (AVWC) may perform the following procedures as part of the diagnosis and treatment of your health condition:

**Common diagnostic procedures:** e.g. venipuncture, Pap smears, laboratory tests, etc.

**Minor office procedures:** e.g. dressing a wound, ear cleansing, etc.

**Prescription drugs:** as medically necessary and allowed under naturopathic prescriptive rights

**Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation, and vitamin injections.

**Botanical medicine:** botanical substances may be prescribed as teas, alcohol-containing tinctures, capsules, tablets, crèmes, plasters, or suppositories.

**Chinese medicine:** Chinese medical interventions may include the use of acupuncture, electro-acupuncture, moxibustion, or Chinese herbs.

**Electrotherapy:** the use of electrical stimulation devices such as ultrasound or microcurrent devices.

**Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

**Lifestyle counseling and hygiene:** education and discussion concerning the promotion of wellness (e.g. recommendations for exercise, sleep, stress reduction, diet, etc.) as well as addressing obstacles to quality of life and health (e.g. smoking, poor lifestyle choices, food allergies, etc.)

**Naturopathic psychological counseling:** addressing minor mood and psychological problems.

**Contraception Counseling and management**

I recognize the potential risks and benefits of these procedures, which include but are not limited to:

Potential risks: allergic reactions to herbs and/or supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injection, venipuncture, or procedures.

Potential benefits: restoration of health, return of maximal functional capacity, relief from symptoms including pain, injury and prevention of disease or its progression.

I agree to inform my AVWC clinician of any disease process that I am suffering from and any medications or over the counter drugs that I am currently taking. I will also advise my doctor immediately if I am pregnant, suspect that I am pregnant, or if I am or will begin breast-feeding.

Having read and fully understood the items described above, I hereby authorize the AVWC to perform the described medical procedures, as necessary to facilitate my diagnosis and treatment. I understand that no guarantees have been given to me by AVWC regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I am also free to ask question about my care that my clinician will answer to the best of their ability.

I further understand that a medical record will be kept of the health services provided for me and that this record will be kept confidential unless otherwise directed by myself, my representative, or as required by law. I acknowledge that I can request to view my medical record at any time and can request a copy of it by paying a copying fee. 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 the clinicians at AVWC may be constrained in their activities by the rules and laws of the State of Washington, my insurance company, and the federal government.

\_\_\_\_\_  
Date

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Signature of Patient or Patient Representative