NATUROPATHIC MEDICINE of Southern Arizona | Laser Therapeutics

2469 N Country Club Rd • Tucson, AZ 85716
Phone: 520-577-6888 • Fax: 520-325-0898
www.DoctorAsTeacher.com

INFORMED CONSENT FOR NATUROPATHIC PATIENTS

Please read and sign the following in order to completely understand the risks and benefits of Naturopathic Medical Care.

I ______________________________, hereby authorize this medical office to perform the following specific procedures as necessary to facilitate my diagnosis and treatments:

Minor office procedures: e.g. dressing a wound, ear cleansing.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters or suppositories.
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: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Physical Medicine: manual therapy, therapeutic exercise, and energetic medicine.
Psychological counseling.

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

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medication, inconvenience of lifestyle changes, injury from injections, venipuncture, or procedures.
Notice to pregnant women: all female patients must alert the doctor if they know or suspect that they are pregnant. Some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by this medical office 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 accept responsibility for the medical charges incurred by myself or the patient that I am guardian over. I agree to pay all bills at the time of service in full, unless other arrangements are made with the Clinic Director.

I realize that I play an integral role in my healing process and that in order to produce results I must take responsibility for my health.

By making this appointment and visiting with a provider of this medical office you are making an investment in your health.

Name of patient (please print) ____

Patient's signature ____ Date ________

Guardian or Spouse authorizing care ____________________________ Date ________

CANCELLATION POLICY

As a courtesy to this medical office and other patients, we ask that you **agree to give a minimum of twenty-four hours notice to reschedule or cancel any appointment.** In the event of multiple missed appointments this office may, at our discretion, require a non-refundable deposit in order to hold future appointment times.

We strive to stay on time, scheduling appointments on the half-hour. In consideration of other patients' time, we ask that you are on time for your appointments. If you arrive late, we will do our best to accommodate you, which may necessitate reducing treatment time so that the next patient may begin their treatment on schedule. We thank you for your consideration.

Patient's initials _________ Date ________

SUPPLEMENT RETURN POLICY

To insure the optimum quality of our physician grade supplements, we apologize that we cannot accept returns on these items once they have been purchased and have left the office:

any opened supplements
any oil supplements
any softgels

All other unopened supplements may be returned within one week of purchase.

*Please note: Some of the supplements Dr. Smith prescribes can be purchased at health food stores or other locations. **Dr. Smith can only vouch for the quality and potency of the supplements that he offers through his office.**

Patient's initials _________ Date ________