MISSION NATUROPATHIC CLINIC
202 – 2900 PANDOSY ST, KELOWNA, BC V1Y 1V9 • (250) 862-8791

Naturopathic Informed Consent

A Naturopathic Doctor, Dr. Alana Berg, Dr. Andrea Chambers, and/or Dr. Audrey Wolter, will conduct a detailed case history and physical exam, as well as utilize various blood, salivary and/or urinary laboratory reports as part of the treatment work-up. Associates may also assist in this process. Some treatments that may be prescribed include but do not fully encompass: nutrition, herbs, homeopathy, acupuncture, naturopathic manipulation, hydrotherapy, lifestyle counselling, injection therapies, neural therapy, trigger point injections, chelation and IV therapy.

All patients agree to inform the practitioners of all health conditions and changes, as well as new conditions throughout treatment. All female patients must alert the health care practitioner if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

_____ (print full name)

As a patient of Mission Naturopathic Clinic, I have read the information and understand that the form of medical care is based on naturopathic principles and practices. I also 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 directed by myself or unless it is required by law. I also recognize the potential risks that include, but are not limited to, depending on the treatments administered: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs or injectables; pain; fainting, dizziness, itching, numbness, infection, soreness or bruising from venipuncture, injections, IV therapy, or acupuncture; muscle strains and sprains from spinal manipulations; inconvenience of lifestyle changes; scar or wound enlargement, keloid formation, temporary or permanent alteration in sensation, discoloration, the need for additional surgery, infiltration, embolism, injury to nerves, Pneumothorax (air on the outside of the lung), or paralysis from injection therapies, acupuncture, or IV therapy; no benefit from Treatments; or other serious or debilitating injuries. I also recognize that that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may or could arise from the Treatments. *NB: every effort is made to minimize these risks.

I understand that the results are not guaranteed. I understand that selected elements of treatments are undergoing research and evaluation within the scientific and medical community, and are not considered conventional care or treatment. I understand that the treatments are needed to be followed as recommended. Also, no promises or guarantees have been made regarding the anticipated outcome of any tests or procedures.

I have read and understood the above statement, accept the risk and thereby consent to treatment.

I also confirm that I have the ability to accept or reject this care of my own free will and choice at any time. I also verify that I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

Signature _____ Date _____

Witness _____ Date _____

Print parent/guardian's name _____

Signature of parent/guardian _____