

STATEMENT OF INFORMED CONSENT

ALLOPATHIC AND ALTERNATIVE THERAPIES DISCLOSURE & INFORMED CONSENT FOR PATIENTS IN MEDICAL OFFICES:

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended allopathic as well as integrative and complementary procedures that are used to treat this condition and your general health. While the risk of complications or side effects from any treatments is rare, it is our policy to inform our patients about them. These complications may include, but are not limited to, soreness, bruising, inflammation, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications of specific treatments is available upon request.

The way in which we choose to treat people will often be different than the conventional care of your MD. It is our policy to always inform you of the procedure being performed and any risks and alternative treatments available to you. If your practitioner's explanation is not to your satisfaction, please ask for more information.

Please recognize that treatment you receive in this clinic is voluntarily and you are voluntarily consenting and authorizing these treatments and procedures. Please understand that you can refuse treatment and or procedures at any time and such requests will be respected.

By reading this, you understand that no warranty or guarantee has been made to as to result of care. You understand that Jennifer Silapie N.D. is a Naturopathic Physician. It is important that you provide all pertinent information in order to facilitate proper treatment and the best medical care possible. Reactions to treatment can be minimized when the doctor is carefully told about all medications you are on including prescription, herbal, and over-the counter medications. There is some risk of reaction to treatment that cannot be predetermined, and that it is important for you to contact the doctor immediately if a reaction occurs in order to remedy the situation as soon as possible.

By signing this, you understand and agree to use prescribed alternative therapies as a compliment to any treatment or therapy recommended by a medical doctor. You agree that you will not discontinue any medications or treatment without the approval of the prescribing doctor.

I have been given an opportunity to ask questions about my condition, conventional treatment, integrative and complementary treatment, alternative forms of treatment, risks of treatment, risks of non-treatment, procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I have read and understand the above statements regarding treatments and side effects.

Patient Signature or Guardian if patient is a minor

Date