Olympia Natural Medicine

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Please review this form, sign, date it, and bring it to your first appointment.

STATEMENT OF INFORMED PATIENT CONSENT

ALLOPATHIC AND ALTERNATIVE THERAPIES DISCLOSURE AND 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. To inform you involves educating you whether the treatments and/or procedures recommended for this condition contain any risks or hazards. This education also involves informing you of the benefits that are involved in a treatment or procedure. This disclosure is an effort to make you better educated so that you may make an informed decision to give or withhold your consent for the treatment or procedure recommended.

NOTICE: Refusal to consent to the treatment or procedure should not affect your right to future care or treatment.

I voluntarily request Dr. Karyn White, N.D., as my naturopathic physician, to treat my condition. I understand that the following allopathic as well as integrative and complementary procedure(s) are planned for me and I voluntarily consent and authorize these treatments and procedures. I understand that I can refuse treatment and or procedures at any time.

I understand that no warranty or guarantee has been made to me as to result of care. I understand that Karyn White N.D. is a Naturopathic Physician. It is important that I give her all my 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 I am on including prescription, herbal, and over-the counter medications. I also understand that there is some risk of reaction to treatment that cannot be predetermined, and that it is important for me to contact the doctor immediately if a reaction occurs in order to remedy the situation as soon as possible.

I understand and agree to use prescribed alternative therapies as a compliment to any treatment or therapy recommended by my medical doctor. I agree that I 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 certify this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

Patient Signature: _____ Date: _____