DR. COLLEEN HARTWICK
NATUROPATHIC PHYSICIAN

INFORMED CONSENT

***Please complete and sign this form before your first visit.

Patient Name: _____ Phone No. _____
Address: _____ Attending ND: Dr. Colleen Hartwick
City/Town: _____ Province: _____

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. A thorough case history in addition to a screening physical exam, which may include a breast exam, may be conducted during your visit. Gentle, non-invasive techniques are used in order to stimulate the body's inherent ability to heal itself.

When you fill out the intake forms prior to your first visit, please ensure that all of the information you provide is complete and accurate so that we can prevent any adverse drug reactions or interaction or from undertaking treatment which may worse an existing condition.

The following represents the spectrum of treatments that we may undertake to address your health concerns:

Acupuncture/Traditional Chinese Medicine	Botanical Medicine
Clinical Nutrition	Homeopathic Medicine
Naturopathic Manipulation	Lifestyle and Dietary Counseling
Organotherapy	Drainage and Detoxification
Gemmotherapy	

I understand that although naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to:

- Aggravation of pre-existing conditions and symptoms
- Allergic reactions to supplements or botanicals
- Pain, bruising or keloid formation from acupuncture
- Fainting from acupuncture
- Muscle strains, sprains, and/or disc injuries from spinal manipulations
- Potential for stroke or emboli from cervical manipulation

I understand:

- Any questions I have will be answered by the ND to the best of their ability.
- I do not expect the ND to be able to anticipate and explain all risks and complications and wish to rely on them to exercise judgment during the course of any and all diagnostic procedure(s) and or therapeutic procedure(s)/plan, which the ND feels at the time, based upon the facts then known, are in my best interest.
- Treatment results are not guaranteed.
- I am always at liberty to seek or continue care from another qualified health care provider(s).

I, _____, hereby understand the risks of Naturopathic Medical treatment as stated above and know that I may ask the physician to explain any risks to specific treatments as they come up. I also understand that I may refuse any treatment that is offered at any time. I will rely on the Naturopathic Physician to exercise his/her best

judgment in my best interests based on his/her present knowledge of my condition and the proposed treatment method.

I understand that a record will be kept of health services provided to you. This record will be kept confidential and will not be released to others unless you give your consent or the law requires it. You may look at your medical record at any time and can request a copy of it by paying the appropriate fee for copying charges

I confirm that I have read this agreement and consent to any treatments from my chosen Naturopathic Physician of this clinic and I understand that I can withdraw my consent to any treatment or to disclosure of personal information at any time. I also understand that I will be responsible for any fees incurred during care and treatment at this clinic.

Signature of Patient: _____ Date: _____
Guardian Signature (if <18yrs): _____ Date: _____

OUR FEES

Adult Naturopathic Initial visit (75-90 mins): $270

Pediatric Naturopathic Initial visit (45-60 mins): $200

45-minute Follow-up Visit: $150

30-minute Follow-Visit: $105

20-minute Follow-up: $85

10-minute Follow-up: $45

****PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED****

Payment can be made by cash, debit, VISA/MC, electronic money transfer (EMT).

I have read the above and understand that I am responsible for all charges relating to my visit.

Patient Name (please print): _____
Signature: _____ Date: _____
Guardian Signature: _____ Date: _____

Cancellation Policy

If you cannot attend an appointment, please give 24 HOURS NOTICE so that another patient may receive care during that time. If 24 hours notice is not given, you will be billed for 100% of the cost of your visit.

I have read the above and understand that I am responsible for all charges relating to my visit.

Patient Name (please print): _____
Signature: _____ Date: _____
Guardian Signature: _____ Date: _____