

North Coast Family Health, Inc.  
500 Market Street, Suite 1F  
Portsmouth, NH 03801  
603-427-6800

## Informed Consent for Treatment

I \_\_\_\_\_, hereby authorize North Coast Family Health, Inc. to provide naturopathic medical care to me, including diagnostic, therapeutic and other services necessary to facilitate my diagnosis and treatment. I understand that these services may include, but not be limited to the following:

- **Common diagnostic procedures:** e.g., venipuncture, pap smears, radiography, laboratory, x-ray
- **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
- **Psychological Counseling**
- **Contraception**
- **Immunization**

**I understand and recognize that there are potential risks and benefits of the treatment provided to me, which are described generally below. I understand that I should discuss any concerns I have regarding the potential risks and benefits with the North Coast provider treating me.**

**Potential risks:** allergic reactions to prescribed herbs and supplements, side effects of natural medication, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

**Potential benefits:** restoration of health and 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.

**Notice to Pregnant women:** All female patients must alert the naturopathic 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 provision of treatment to me by North Coast Family Health, Inc., realizing that no guarantees have been given to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue my treatment at any time.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Patient Representative or Guardian