**Declaration and Consent for Naturopathic Care**

I would like to take this opportunity to welcome you to our clinic. As a naturopathic doctor (ND) I will conduct a thorough case history, a physical exam and **may** utilize specific blood, urinary or other laboratory reports as part of the treatment work-up. I integrate supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling to assist the body's ability to heal and to improve the quality of life and health.

**Statement of Acknowledgement**
Printed name of patient: _____

As a patient of Dr Kinnon, I have read the information and understand that the form of medical care is based on **naturopathic** and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. **Slight** health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from venipuncture or acupuncture
- muscle strains and spasms, disc injuries from spinal manipulations

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient of Dr. Kinnon is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. I understand results are not guaranteed.
- I understand that a record will be kept of my visits. This record will be kept confidential and **will not be released** without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for **payment at the time services are rendered.** Dispensary items must be paid for in full before leaving the office.
- I am aware that **24 hours notice** must be given for all cancelled appointments or a **cancellation fee** will be applied.
- I understand that Dr. Kinnon reserve the right to determine which cases fall outside of her scope of practice, in which case the **appropriate referral will be recommended.**

I consent to receive naturopathic treatment. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: _____ Date: _____