INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the doctor, Stephen Knight, ND, of Natural Health Partners, Inc. to perform or refer for the following specific procedures as necessary, as well as others that are deemed appropriate, to facilitate my diagnosis and treatment:

- **Common Diagnostic procedures:** e.g., venipuncture, pap smears, radiography, laboratory work, EKG, etc.
- **Minor office procedures:** e.g., dressing a wound, prolotherapy, etc.
- **Medicinal use of nutrition:** e.g., therapeutic nutrition, nutritional supplementation, intramuscular vitamin & herbal injections, IV nutritional and mineral support, etc.
- **Botanical medicine:** botanical substances may be prescribed both internally and externally. Homeopathic remedies, often highly dilute quantities of naturally occurring substances, may also be used.
- **Hydrotherapy:** e.g., constitutional hydrotherapy treatments with electrostimulation, contrast baths, etc.
- **Physical medicine:** e.g., ultrasound, low and high volt electrical muscle stimulation, transcutaneous stimulation, microcurrent stimulation, diathermy, infrared and ultraviolet therapies, acupressure, naturopathic adjustments, massage, traction, neuromuscular techniques, stretching, etc.
- **Pharmaceutical medicine:** e.g., supplementation of hormones, chelation therapy, as well as the pharmaceutical drugs listed on the California State naturopathic formulary.
- **Lifestyle counseling and hygiene:** e.g., diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, biofeedback, and balancing of work and social activities.
- **Counseling:** e.g., psychological, grief, etc.

I recognize the potential risks and benefits of these procedures as described below:

- **Potential risks:** allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, bruising/injury from injections, side effects or unexpected complications from prescribed hormones or pharmaceuticals, and more.
- **Potential benefits:** restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, prevention of disease or its progression, and allowing the body to gracefully age with optimal health and enjoyment of life.
- **Notice to pregnant women:** All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

I recognize that if I withhold information, specifically requested by the doctor, or do not inform the doctor of any related information that I reasonably believe could impact the doctor's assessment of my situation, I will be impeding his ability to provide me with the best possible care. I further realize that Dr. Knight provides adjunctive care and is **NOT** acting as my primary physician, and I need to continue receiving medical advice and treatment from my primary physician and I am **NOT** to discontinue any prescribed treatments or medications without **SPECIFIC** directions. I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, **if an emergency medical condition arises**, seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (printed)_____

PATIENT SIGNATURE _____ **Date:** _____

(or if patient representative – indicate why signing on their behalf _____)