

Zepp Wellness

Naturopathic medicine is the treatment and prevention of diseases by natural means. Your Naturopathic Doctor will take a thorough case history, a screening physical examination, including a urine samples. If your case requires, the physical may include more specific examinations such as breast, gynecological, rectal, prostate or genital exams.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

There are some slight health risks to treatment by naturopathic medicine. These are rare, but include, and are not limited to:

- Possible aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.
- Muscle strains and sprains, disc injures from spinal manipulation.

Statement of Acknowledgement

As a patient of Zepp Wellness Clinic, I _____ have read the information and understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself in writing or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

The information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs.

With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: _____.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I also confirm that I have the ability to accept or reject this care of my own free will and choice. I accept full responsibility for any fees incurred during care and treatment.

Patient Name (Please Print): _____

Signature: _____

Date: _____