PLEASE NOTE THAT THIS FORM MUST BE SIGNED
PRIOR TO YOUR 1ST APPOINTMENT

ZIEGLER
INTEGRATIVE HEALTH
Care for the whole person

INFORMED CONSENT

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. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your naturopathic doctor will take a thorough case history and perform a physical examination. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important that you inform your doctor immediately of any disease process that you are suffering from and any medications/over the counter drugs/supplements that you are currently taking. Please advise your doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight health risks associated with treatment by naturopathic medicine.

These include but are not limited to:

- Possible aggravation of pre-existing symptoms
- Allergic reactions to certain supplements and herbs. Please advise your doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy.
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.
- Muscle strains and sprains, disc injuries from spinal manipulation.

Statement of Acknowledgement

As a patient of Ziegler Integrative Health, under the care of Dr. Allison Ziegler, I _____ have read the above 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 have access to 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 consent to diagnostic and therapeutic procedures mentioned above. 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 name): _____

Signature of Patient or Guardian: _____ Date: _____