

Synergea Family Health Centre
9 Arbour Lake Drive NW
Calgary, AB T3G 5G8
P (403) 247-2947 F (403) 202-3084

Consent Form for Naturopathic Medicine

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 capacity. Your Naturopathic Doctor will take a thorough case history, perform a pertinent physical exam and may suggest labwork or request copies of labwork previously completed by your family doctor or specialist.

It is very important that you inform your Naturopathic Doctor of any disease process that you are suffering from and any medications or over the counter drugs that you are taking. Please advise your Naturopathic Doctor if you are nursing, are pregnant or become pregnant throughout the course of your treatment.

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

As with any form of medical intervention, there can be risks associated with treatment by naturopathic medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reaction to supplements or herbs
- Pain, bruising or injury from injections

I understand that a record will be kept of the health services provided to me. The record will be kept confidential and will not be released to others unless so directed by myself or if the law requires it. If required, I understand that my naturopathic doctor may discuss my case with other healthcare providers.

I understand that results are not guaranteed. I do not expect naturopathic doctors to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Naturopathic care 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 at any time.

Patient Name: (please print name) _____
Signature of patient or guardian: _____

Dr. Chelsea Frederick ND
Dr. Lisa Keen ND

ND Signature: _____