NATUROPATHIC MEDICINE

INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Jennifer J. Stagg, ND LLC to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures (e.g. physical exams, venipuncture, Pap smears), minor office procedures (e.g. dressing a wound, ear irrigation), medicinal use of nutrition (therapeutic nutrition, nutritional supplementation), botanical medicine (botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories), homeopathic remedies (the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses), lifestyle counseling and hygiene (diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities), psychological counseling, physical medicine (osseous manipulation, soft tissue manipulation, electrotherapies, hydrotherapies, paraffin bath, intersegmental traction, cupping, acupuncture).

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, injury from venipuncture or procedures, aggravation of pre-existing symptoms, discomfort, pain, bruising, burns, and lightheadedness.

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, and prevention of disease or its progression.

Notice to all pregnant women: all female patients must alert the doctor if they know or suspect they are pregnant as some of the therapies used could present a risk to pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Jennifer J. Stagg, ND LLC or any of her personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that Jennifer J. Stagg, ND LLC will keep a record 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 or my representative, or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying an appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that any questions I have will be answered by my physician to the best of her ability.

_____ _____

Date Name of Patient

_____ _____

Signature of Patient Signature of Patient Representative or Guardian