Informed Consent and Request for Care

I, _____, do hereby give my consent to services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient of Sirona Integrative Health. I understand that patient care is directed by licensed health care providers. I consent to services rendered to me under the instructions of these professionals, as well as support staff who may be associated for the purpose of consulting and services provided within the full scope of their license(s).

I understand that Dr. Williams provides naturopathic and allopathic services, however, she does not provide primary care services at Sirona Integrative Health. I agree to establish care with a primary care physician for all of my primary care needs. INITIAL HERE:_____

I, _____, hereby request and consent to examination and treatment by providers and support staff at Sirona Integrative Health. I understand I have the right to ask questions and discuss to my satisfaction with the above mentioned providers and/or support staff regarding:

- My suspected diagnosis(s) or condition(s).
- The nature, purpose, goals, and potential benefits of the proposed care.
- The inherent risks, complications, potential hazards, and/or side effects of treatment or procedure.
- The probability or likelihood of success.
- Reasonable available alternatives to the proposed treatment procedure.
- Potential consequences if treatment or advice is not followed and/or nothing is done.

Medical and Naturopathic evaluation information:
I understand that medical evaluation and/or Naturopathic evaluation treatment may include, but is not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic, and neurological assessments) as deemed necessary based on presenting complaints.
- Common diagnostic procedures (including venipuncture, pap smears, laboratory testing of blood, saliva, urine, and stool.

- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements, and intravenous vitamin injections.
- Trigger point injection therapy with or without vitamin substances.
- Prolotherapy or Platelet Rich Plasma injections.
- Botanical/Herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams, pastes, plasters, washes, or other forms.
    - I understand that some herbs may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform my provider. INITIAL_____
- Homeopathic remedies (highly diluted quantities of naturally occurring substances).
- Counseling (including but not limited to visualization for improved lifestyle strategies).
- Over-the-counter and prescription medications.
- Intravenous (IV) Therapy treatments including Nutrient drips and pushes. This treatment involves inserting a needle and injecting a standardized formula into veins or muscles.
    - There may be some discomfort at the site of treatment and it is my responsibility to inform my physician or support staff of any burning, pain, or negative reactions that I may be experiencing. INITIAL_____
    - During treatment, it is possible for the fluid to leak out of the vein into the surrounding tissue. I understand that although this infiltrated fluid may cause pain, it is not dangerous to my health and my body will absorb the fluid. INITIAL_____
    - I realize that during and after my treatment I may experience temporary discomfort at the site of treatment. There is no stated or implied guaranty of success or effectiveness of any specific treatment. INITIAL_____
    - I am free to withdraw my consent or participation in these treatments at any time. INITIAL_____
    - Possible risks and complications associated with these procedures may include: Pain, bruising, or infection at injection site Inflammation of vein used for infusion (phlebitis) Severe allergic reaction or anaphylaxis, resulting in cardiac arrest, possibly death.
- I, _____, have read the above risks associated with treatment options. I testify that I understand the benefits and risks of the treatments listed above and agree to the treatment plan discussed with my provider.

Patient Name (print): _____ Provider Name: Dr. Michelle Williams

Patient Signature: _____ Provider Signature: _____