Informed Consent to Treat

Northwest Integrative Medicine
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I hereby request and consent to the performance of chiropractic procedures (including various modes of physical therapy and diagnostic testing and examination) and/or to the performance of acupuncture/electro-acupuncture (including needle puncture, point injection and infrared therapy) and/or to the performance of naturopathic procedures (including examination, diagnostic testing and the use of natural substances such as vitamins, minerals, botanical medicines, bio- identical hormones and prescription drugs) on me (or on the patient named below, for whom I am legally responsible) by Dr. Lecovin; a licensed naturopath, chiropractic physician and acupuncturist.

I have had an opportunity to discuss with Dr. Lecovin the nature and purpose of naturopathic medical Care, chiropractic and/or acupuncture and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, naturopathic medicine and acupuncture there are some risks to the exam and treatment including, but not limited to: Chiropractic: fractures, disc injuries, strokes, dislocations and sprains, temporary soreness, bruising and discoloration; Naturopathic Medicine: drug side effects, nutrient-drug interaction, herb-drug interactions and (as a result of osteopathic manipulation) fractures, disc injuries, strokes, dislocations and sprains, temporary soreness, bruising and discoloration; Acupuncture: bruising, organ puncture, infection, local tenderness, drowsiness.

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, supplements, prescribed medications, prescribed exercises and lifestyle modification will increase the effectiveness of my care and enhance or maintain the results. I understand a referral to another physician or specialist may be necessary due to the nature of my condition and limitations in the scope of practice of Naturopathic Medicine, Acupuncture and/or Chiropractic.

I am aware that Naturopathic Physicians are considered primary care providers in the state of Washington. I acknowledge that the scope of practice of a Naturopathic physician has limitations including limited prescription privileges and lack of hospital privileges. Consequently a referral to a specialist or emergency room may be deemed necessary under certain circumstances and in my best interest.

Furthermore, I understand that some techniques such as neuromuscular reeducation or myofascial release may involve working on muscles located near the breasts, buttocks and/or groin. The doctor will exercise care in keeping sensitive areas draped during such procedures and if at an time either before or during the treatment I am uncomfortable with work in these areas I will verbally inform the doctor and a written note will be documented in my chart and signed by myself, the doctor and a witness.

I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to be able to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Signature Patient's Guardian Signature (IF MINOR)

_____ _____

Witness (Staff Signature) Date