Dr. Suzanna Paris ND

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DECLARATION & CONSENT TO TREATMENT & PAYMENT

Naturopathic Doctors minimize the risk of harmful side effects by supporting the body's own ability to heal and by using the least invasive procedures for diagnosis and treatment whenever possible. However, even the gentlest therapies have potential for complications.

Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease, or in specific patient populations such as pregnant or lactating women, very young children, or patients taking multiple medications.

It is very important that you inform your Naturopathic Doctor immediately of:

- aggravation of pre-existing symptoms
- allergic reactions to supplements or herbs
- pain, bruising or injury from blood draws needles

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 or when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fee.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of his/her ability.

I understand that the results are not guaranteed.

I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications.

I will rely on the Naturopathic Doctor to exercise judgment during the duration of care which they feel at that time is in my best interests, based on the facts then known.

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 and to discontinue participation in these procedures at any time.

If I am unable to make my appointment I must provide advance notification within 24 hours in which case no charge will be applied.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

l. Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving from another licensed health care provider, or may receive in the future

ll. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider

lll. The treatment and therapies rendered or recommended by Dr. Paris may be different than those usually offered by a medical doctor or other licensed health care provider.

I DECLARE that I have received a full and complete explanation of the treatment of services that I may receive and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, as well as other applicable fees.

I understand that there is a fee for completing insurance forms, letter writing, and telephone consultations greater than 10 minutes and emails that take greater than 10 minutes to answer.

Notice of 48 hours required for appointment cancellation, otherwise a $50 administrative fee will be charged.

Patients' Full Name_____

Date of Consent:_____

Patient'sSignature_____

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