PATIENT INFORMATION SHEET

Last Name: _____

First Name: _____

Date of Birth: _____ Age: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____

Email: _____

Emergency Contact Information – Person to Notify:

Name: _____

Relationship: _____

Phone: _____

Address: _____ City: _____ State: _____ Zip: ___

Allergies: _____

Current Medications:

Medication	Dose	How long have you taken?	Prescribed By: (or Self)	Purpose?	Side Effects

Referred By: _____

CONSENT AND AUTHORIZATION FOR INTRAVENOUS THERAPY PROCEDURES

Patient Name: _____ Date of Birth: _____

Partners in Health Care, Naturally provides facilities to perform intravenous and intramuscular therapy. You have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Procedures are not performed until you have had an opportunity to receive such information and to give your informed consent.

Intravenous (IV) and Intramuscular (IM) Therapy:

- Definition and Explanation: IV (Intravascular) treatment involves inserting a needle into your veins and then injecting a nutrient solution into the vein. IM (Intramuscular) treatment involves inserting a needle into your muscle and injecting a nutrient solution into the muscle. The formula that is injected via IV or IM will be discussed with you.

- Risks of IV/IM therapy:
    - Discomfort, bruising, pain, infection and infiltration at the site of injection
    - Phlebitis (inflammation of the vein used for injection)
    - Severe allergic reaction, anaphylaxis, syncope, blood clot, pulmonary embolism, cardiac arrest and death

- Alternatives to IV/IM therapy include oral supplementation and/or dietary and lifestyle changes.

- Benefits of IV/IM Therapy:
    - Nutrients are not affected by stomach or intestinal disease.
    - Total amount of fluid and nutrients enter the circulation, therefore it is available to the tissues.
    - Higher dose of nutrients can be given by vein than by mouth without nausea, abdominal discomfort, or diarrhea.

Your signature below means that:

- You understand the information provided on this form and agree to the procedure.
- The procedure(s) set forth above has been adequately explained to you by one of our physicians/preceptees.
- You have received all the information and explanation you desire concerning the procedure.
- You authorize and consent to the performance of the procedure(s).

_____ _____ _____

Patient/Representative Signature Date Time of Day

_____

(If signed by a representative, indicate relationship)

CONSENT TO TREAT

Name: _____

Date of Birth: _____

I understand that this is a Naturopathic Medical Clinic and I give consent to this form of treatment. I understand that a Naturopathic Doctor is a physician who specializes in natural medicine. I am aware that with the guidance of the doctor, I may choose to be an active partner in helping determine my treatment plan and I will ask the doctor to explain when there may be a treatment that I am unfamiliar with or do not understand. I am aware that any type of medicine, conventional or otherwise, may have potential side effects. I will inform the doctor of any known allergies and provide previous medical history as necessary.

I hereby request Naturopathic Medicine treatment and therapies, including nutritional consultations and other procedures, including various modes of physiotherapy, nutritional therapy (including IV or IM injections if indicated) and diagnostic procedures, including laboratory testing, on me (or the patient named below for whom I am legally responsible) by a Doctor of Naturopathic Medicine and/or licensed doctors of Naturopathic Medicine who now or in the future treat me while employed by, working or associated with, or serving as back-up doctor in the offices of Partners in Health Care, Naturally. I also understand that Naturopathic Interns working under the doctor's direct supervision or the RN employed by the doctor may be directed by the doctor to perform certain diagnostic or therapeutic procedures on me during the time of my care.

Printed Name of Patient: _____

Patient/Guardian Signature: _____ Date: _____

Financial Agreement

I claim full financial responsibility for services rendered by Partners in Health Care, Naturally and understand that full payment is required at the time of service.

Signature: _____Date: _____

Cancellation/ No Show Policy

I understand that Partners in Health Care, Naturally requires a 24-hour cancellation notice for all appointments. I understand that my failure to furnish notice will result in a charge of $45, which must be paid in advance of making a replacement appointment.

Signature: _____ Date: _____