LEXINGTON NATURAL HEALTH CENTER

INFORMED CONSENT FOR TREATMENT

Printed Patient's Name: _____

I hereby authorize the Naturopathic Doctors and other practitioners of the Lexington Natural Health Center (hereinafter referred to as "LNHC") to perform specific therapies and/or procedure(s) as necessary to facilitate my evaluation and treatment included but not limited to the following:

- **Common Lab procedures:** e.g. venipuncture, pap smears, laboratory evaluation of blood, urine, stool and saliva.
- **Physical exam:** e.g. general, gynecological, musculoskeletal, neurological.
- **Minor office procedures:** e.g. dressing a wound, ear cleansing.
- **Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids, and other nutritional or therapeutic substances.
- **Botanical medicine:** botanical substances (herbal medicines) may be prescribed as teas, extracts, capsules, tablets, powders, essential oils, suppositories, crèmes, plasters, or other topical preparations.
- **Homeopathic medicine:** 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, fasting, elimination diets, promoting of wellness including recommendations for exercise, sleep, stress, reductions, and balancing of work and social activities.
- **Physical medicine:** e.g. hydrotherapy (use of hot and cold water)

Potential Risks include, but are not limited, to allergic reactions to prescribe herbs and supplements, side effects of natural medicine, inconvenience of life style changes, and venipuncture for lab evaluation.

Potential benefits include, but are not limited to, 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 Pregnant Women: All female patients must inform the treating practitioner if they know or suspect that they are pregnant as some of the therapies and/or procedures described above may present a risk to the pregnancy.

Notice to Nursing Mothers: All female patients must inform the treating practitioner if they are breast feeding as some of the therapies and/or procedures described above may present a risk to the nursing child.

I understand that the therapies and/or procedures recommended by LNHC are not all accepted by the United States Food and Drug Administration.

I understand the practitioners of LNHC are not primary care physicians or MD's. They are licensed ND's, naturopathic doctors. I understand the therapies and/or procedures that I will be receiving at LNHC are supplementary care to my primary care physician and/or medical doctor ("M.D.") and/or ("D.O.") specialist(s).

Over

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I understand that the therapies and/or procedures recommended by LNHC are not intended to replace those treatments prescribed by my M.D. and/or D.O.

I recognize that there are potential risks and benefits of the therapies and/or procedures. I understand it is my right and responsibility to ask questions and discuss, to my satisfaction, the potential risks and benefits as well as reasonable alternatives to the therapies and/or procedures before I begin any therapies and/or procedures offered to me by the LNHC.

With this knowledge, I voluntarily consent to the above therapies and/or procedure(s) realizing that there are no guarantees and/or warrantees in using the above therapies and/or procedure(s) that will be administered to me by LNHC or any of its personnel regarding the improvement or cure of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these therapies and/or procedure(s) at any time.

I understand that LNHC may recommend changes to my therapeutic plan as necessary to facilitate my treatment. I intend this informed consent form to cover the entire course of treatment(s) for my present condition and any future conditions for which I seek treatment at LNHC.

I certify that I have read and fully understand this consent. I further certify that I have full authority and accept full responsibility to execute this consent for and on behalf of the above-named patient and that I am signing freely and voluntarily.

_____ _____

Date Signature of Patient

_____

Signature of Patient Representative or Guardian

_____ _____

Date Signature of Doctor

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