Informed Consent

Welcome to the Natural Family Health Clinic (NFHC). Your questions and participation are encouraged in all aspects of your care. Please read the following statements regarding your working relationship with the NFHC and its provider(s):

1. Any treatment or advice provided to me as a patient of the NFHC is not mutually exclusive from any treatment or advice that I may be receiving now or in the future from another health care provider.
2. I am at liberty to seek or continue medical care from another physician or other health care provider and no physician, provider, or staff member of the NFHC is recommending that I refrain from seeking or following the advice of another licensed health care provider.
3. The treatment or therapies provided or recommended by the NFHC may be different from the treatment or therapies typically offered by another licensed health care provider.
4. Naturopathic therapeutic procedures are considered safe and effective methods of care. In some circumstances complications may arise. While complications are rare, it is the practice of the NFHC to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. It is our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain these to your satisfaction, please ask for more information.
5. I consent to the use or disclosure of my protected health information by the NFHC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of the NFHC. I understand that diagnosis or treatment of me by my provider(s) at the NFHC may be conditioned upon my consent as evidenced by my signature on this document.
6. My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health, or condition that identifies me, or there is reasonable basis to believe the information may identify me.
7. I agree to receive electronic communications with the NFHC including email, text, and voicemail.
8. I have the right to revoke this consent at any time, in writing, except to the extent that my provider(s) or the staff at the NFHC has taken action in reliance on this consent.

I have read and understand the above-stated policies of the NFHC and will comply with them in all respects.

Patient Name (print):_____ Date:_____

Patient Signature:_____ Date:_____