



Pacific Integrative Oncology

1471 Pearl Street, Suite 2 · Eugene, OR 97401 · (541)338-9494

Informed Consent

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR FIRST APPOINTMENT

During your initial visits, your naturopathic doctor will take a thorough case history, do a physical examination, and when indicated, order blood and urine samples. The physical examination may include more specific examinations.

Methods, Procedures and Therapeutic Approaches: I am aware that Naturopathic Physicians are not considered primary care providers in the state of Oregon. 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.

Potential Risks: Even the gentlest of therapies may cause complications in certain physiological conditions (e.g. pregnancy, lactation, very young children or those taking multiple medications). Some therapies must be used with caution in certain diseases such as diabetes, cancer, heart, liver or kidney disease. It is very important that you inform your doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) you are taking. If you are pregnant, suspect you are pregnant or you are breastfeeding, advise your doctor immediately.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, mitigation of side effects of medications and prevention of disease or its progression.

I understand that a record will be kept of health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. **Initials:** _____

I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not a guarantee. I do not expect the doctor to be able to anticipate and explain all risks and complications. I understand and am informed the results of treatments may vary and 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, specialist or emergency room may be necessary due to the nature of my condition and limitations in the scope of practice of Naturopathic Medicine. **Initials:** _____

I understand that charges are to be paid at the time of the visit unless specific arrangements have been made **prior** to my scheduled appointment. Payment for all supplements are due at the time of purchase. **Initials:** _____

I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or late cancellations (less than 24 hours). **Initials:** _____

I have read and understand the above-stated policies and information. 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.

Patient Name (please print): _____ **Date:** _____

Signature: _____