true nature
HEALTH CLINIC

Welcome to the clinic. We look forward to providing for your health care needs. During your appointments, we encourage your questions and participation in all aspects of your care. Please **read and initial** the following statements.

Initial

____ **Refrain from wearing scents for the health of our clients. If wearing, you may be asked to leave and have the option of a telephone consultation or paying the cancellation fee.**

____ Turn off or silence your cellphone during your visit.

____ Please remove your outdoor footwear in the reception area, you may use booties that are provided or bring your own indoor shoes. This is to help keep allergens to a minimum inside the clinic.

____ To refill any Doctor recommended supplements at the clinic, you must have had an appointment with the Doctor in the last year. Please bring your nutrition sheet with you when picking up more supplements.

____ **There may be times when you may be required to wait as the Doctor is providing needed attention to a current patient.**

____ If you have not seen the doctor in 2 years or longer, you will need to fill in the new patient intake forms and be scheduled for a 55-minute visit to fully address your health concerns.

____ From time to time the clinic may email you updates, newsletters, information about upcoming events, or similar communications. You agree to be contacted at the email address provided. You may opt out of such emails at any time.

____ Payment of services, dispensary items, and other fees are due in full at each visit. The clinic can direct bill to select insurance providers. If we cannot direct bill to your provider, we will provide you with an invoice to submit your own claim.

____ **I acknowledge that my appointments are time set aside for me. Any cancellation notice must be given on a business day and no less than 24 hours before an appointment. Late cancellations or missed appointments will be charged a fee of $50.00.**

Informed Consent

Our clinic follows the principles and practices of Naturopathic Medicine with aim of improving your quality of life and assisting the body's healing process using natural therapies. Our practitioners will take a full case history and may use physical exam, blood, urinary or salivary tests to assist in diagnosis and treatment.

I have read the information and understand that the care I will receive is based on the principles of Naturopathic Medicine.

I confirm that the information provided is complete and inclusive of all health concerns including risk of pregnancy, breastfeeding and all medications, including over the counter drugs and supplements.

I understand that naturopathic medicine, as will all medical treatments, carries a risk of complications. The resolution of symptoms is not guaranteed.

I acknowledge that the doctors and/or practitioners in the clinic may enhance my care periodically by discussing my case with each other. I will inform my naturopathic doctor if this is a concern for me.

I understand that I can accept or reject this care of my own free will and choice. I am here as a patient seeking naturopathic medicine and am not attending the clinic for any other reason or misrepresenting myself in any way to the practitioner without making my intention known to the practitioner and/or staff.

_____
Childs Name if a minor (please print)

_____
Patients Name (please print) OR Parent/guardian if minor-under 18

_____
Patient Signature OR Parent/guardian if minor-under 18

_____
Date

_____
Naturopathic Doctor

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