CONSENT FOR TREATMENT

I hereby authorize Dr. Diane Lee to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **General Diagnostic Procedures** including, but not limited to, venipuncture, pap smears, radiography, blood and urine labwork, general physical exams, neurological and musculoskeletal assessments
- **Psychological Counseling**; **Lifestyle Counseling**; **Exercise Prescriptions**
- **Herbs/Natural Medicines**- prescribing of various therapeutic substances, including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, or tinctures (may contain alcohol), topical creams, pastes, plasters, washes, suppositories, or other forms. Homeopathic remedies, often highly diluted quantities of naturally occurring substances, may also be used.
- **Dietary Advice and Therapeutic Nutrition**- use of foods, diet plans, or nutritional supplements for treatment, which may include intramuscular vitamin injections
- **Soft Tissue and Osseous Manipulation**- use of massage, neuro-muscular techniques, muscle energy stretching, or visceral manipulation, as well as manipulations of the extremities and spine, including traction and craniosacral therapy
- **Thermal Therapies**, including the use of cupping, moxa (warming or indirect burning of an acupuncture point), and hydrotherapies

Potential risks: Pain; discomfort; blistering; discoloration; infection; burns; loss of consciousness; deep tissue injury from needle insertions, topical procedures, heat, or frictional therapies, electromagnetic- and hydro-therapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; aggravation of pre-existing symptoms

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; and prevention of disease or its progression

Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used couple present a risk to the pregnancy. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedure, realizing that no guarantees have been given to me by Dr. Diane Lee. Further, I will hold Dr. Lee harmless and will not ask for indemnity for any of the side effects that may be caused. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

_____	_____	_____
Patient's name (PRINT)	Patient's signature	Date
_____	_____	_____
Guardian/Representative's name (PRINT)	Guardian/Representative's signature	Date

_____
Relationship/Representative's Authority

Notice of Privacy Practices

I have received a copy of the Privacy Practices. I consent to the personal use of my personal health information for the purposes of treatment, payment, and clinic healthcare operations. I am aware that a detailed description of the Privacy Practices of this clinic is available upon request and that a copy is available for my access at www.seattlenaturopathiccenter.com.

Initials _____ **Date** _____

Payment

I agree to pay for any fees for services, costs of supplements and remedies, costs of laboratory tests, or other costs or fees that are not covered by my insurance plan. I furthermore understand that any amount paid at the time of service is not a guarantee of coverage, nor is it indicative of the entire amount that may be owed by me in the event that my insurance does not cover the full amount owed. I understand that there is a 24 hour cancellation policy and that I will therefore be charged a $60 cancellation fee if changes to my appointment are made without 24 hours notice and that I will be charged a $100 "no show" fee for any appointments that I miss without 24 hours notice. For patients without health insurance, payment is due in full at the time of service.

Initials _____ **Date** _____