

# Consent Form Outsmart

Smart Form submission for  
Consent Form for Naturopathic Services.

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## 1. Consent To Treatment

Dear patient,

I would like to welcome you to my care. My practice utilizes the principles of Naturopathic Medicine to assist the mind and body's ability to heal and thrive. A number of different approaches may be used, including but not limited to: Clinical nutrition and Nutritional supplements, Botanical/Herbal Medicine, Acupuncture, Physical Medicine, Intravenous Therapy, Lifestyle Counselling, and Mind-Body Medicine.

The slight health risks of some Naturopathic treatments include, but are not limited to:

- Aggravation of pre-existing symptoms or conditions;
- A small subset of patients experience allergic reactions to certain supplements or herbs. **Please advise me of any allergies you may have;**
- Pain, fainting, bruising or injury from acupuncture;
- Rarely, muscle strains or ligament sprains from spinal adjustments. This may intensify soreness and pain temporarily, and increase the need for treatment; but in almost every case, the issue resolves completely, and there are no long term effects to the patient. These problems happen so rarely that there are no statistics to quantify their probability;
- Although spinal adjustments are used to treat disc herniations successfully, there is a very small risk that an adjustment can aggravate a disc injury, or can cause a disc herniation if the disc is already damaged or weakened. These problems occur so rarely, that there are no statistics to quantify their probability;
- Stroke is VERY uncommon, but it is the most serious possible complication from a neck adjustment. In the May 1994 Chiropractic Report, it states: *"By any medical standard, cervical adjustments are extremely safe treatments. Vertebral artery injury causing stroke is the only serious potential complication. There is a risk rate (incidence) of about .0002%, or one case in two million."* In another study, (Journal of CCA, Vol. 37, No. 2, June 1993) they estimate that the risk of this type of stroke is .0003%, one in three million. I will do an in-depth screening prior to adjusting the neck;

I am trained to handle emergencies should the need arise.

I will conduct a thorough case history. As part of a naturopathic intake assessment, a physical exam and/or specific laboratory tests (blood and/or urinary) may be required and used as part of the treatment work-up (as deemed necessary after a comprehensive intake).

Although Naturopathic Medicine uses very gentle therapies, even these may induce complications in certain physiological conditions such as pregnancy, lactation, very young children, very elderly and in certain conditions including but not limited to diabetes, liver, heart or kidney disease. It is therefore important to **inform me of any illnesses you suffer from or medications you may be taking (prescription or over-the-counter).**

You will receive information about your diagnosis and/or treatment, alternative courses of action, costs, expected benefits, risks, adverse effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

**If you are a female and are pregnant, suspect you may be pregnant or are nursing, please advise me immediately.**

Because of the sensitive nature of the information that you disclose during naturopathic visits, maintaining privacy and protecting your personal information is of utmost importance. My Privacy Policy is such that:

- Only necessary information is collected about you;
- Your identity will be protected at all times. If the need arises, your identifying information will be altered;
- I only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- My privacy protocols comply with privacy legislation and standards of the naturopathic profession's regulatory body.

I will be collecting, using, and disclosing information about you for the following purposes:

- To assess your health concerns, provide healthcare, and advise you of treatment options. In order to provide integrative, collaborative healthcare to the highest standard, this may include sharing relevant information with other Naturopathic Doctors or healthcare providers;
- To communicate with your family doctor and/or referring doctor as deemed necessary for your beneficial treatment;
- To establish and maintain contact with you;
- To remind you of upcoming appointments;
- To allow me to efficiently follow-up for treatment;
- To invoice for goods and services;
- To process credit card payments;
- To collect unpaid accounts and follow up on billing as required;
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who

may be an imminent threat to harm themselves or others.

As a patient of Dr. Mike Tung, ND, I am at liberty to seek or continue medical care from a medical doctor or other health care provider. This consent form is intended 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.
- I understand that I may look at my medical record at any time and may request a copy of it by paying the appropriate fee.
- I understand that Dr. Mike Tung, ND, will answer any questions I have to the best of his ability.
- I understand that any treatment or advice provided to me as a patient of Dr. Mike Tung, ND, is not being provided in place of, or to the exclusion of any other treatment or advice that I am currently receiving or may in the future receive from a physician, surgeon, or any other licensed healthcare provider.
- I understand that the results are not guaranteed. With this knowledge I voluntarily agree to the diagnostic and therapeutic treatments above.
- I understand that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children, or in people on multiple medications.
- I acknowledge that the information I have provided is complete and inclusive of health concerns, including risks of pregnancy; and all medications, including supplements and over-the-counter drugs.
- I understand that treatment advice will not be given over the phone or via e-mail unless directly relating to specifics discussed during a clinic visit.
- I understand that the goods and services provided by Dr. Mike Tung, ND, are **not covered under the Ontario Health Insurance Plan and accordingly, I accept full responsibility for any fees incurred during care and treatment.**
- I understand that due to health regulations, **no supplements can be returned after 1 month.**
- I understand that in order to be provided with quality healthcare, if I have not seen Dr. Mike Tung, ND, in more than 12 months, my appointment will be considered a Return Visit, which will require a full 75 minute appointment.
- I understand that charges are to be paid at the conclusion of each visit unless previous arrangements have been made prior to my scheduled appointment.

- I also understand that the Cancellation policy requires me to cancel and/or reschedule a booked appointment at least 24 hours prior to a given, scheduled appointment. **Cancellations with less than 24 hours notice will incur a charge of the full appointment fee that must be paid prior to the next visit.**

I acknowledge that I have been informed of, and fully understand the above:  Yes  No

Date:

Patient Name:

Patient Email Address:

Clear sign above

### Thank You For Completing The Questionnaire!

Thank you for taking the time to complete this questionnaire. Click the "submit" button to submit this form to your practitioner .