Informed Consent and Request for Naturopathic Medical Care

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You have the right to be informed about your health condition(s) and recommended treatment. This disclosure is to help you become better informed by discussing the potential benefits, risks, and hazards involved in your care.

I, _____, hereby request and consent to examination and treatment by Dr. David L. McHenry II. I understand that as part of the practice of naturopathic medicine, evaluation and treatment may include but are not limited to:

- Physical exams (general, orthopedic, EENT, cardiovascular, pulmonary, abdominal, neurological, urogenital and/or gynecological assessments)
- Common diagnostic procedures (venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (therapeutic massage, deep tissue massage, neuromuscular technique, naturopathic/osseous manipulation of the spine and extremities, muscle energy techniques)
- Physiotherapeutic treatments (acupuncture, cupping, gua sha, moxa, hydrotherapy, therapeutic ultrasound, interferential, pulsed electromagnetic frequency, electrical stimulation)
- Dietary counseling/therapeutic nutrition (use of food, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Regenerative injection therapy with vitamin substances and/or medications (trigger point injections, prolotherapy, neural prolotherapy, platelet rich plasma injections)
- Botanical/herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the form of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams, plasters, washes, or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Counseling
- Over the counter or prescription medications consistent with the Arizona Naturopathic Physicians Medical Board

Potential Benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential Risks: Pain, discomfort, minor bruising, discoloration, blistering, burns, itching, loss of consciousness, deep tissue injury from needle insertions, bleeding, pneumothorax, allergic

reaction to prescribed herbs and/or supplements, soft tissue or bony injury from physical manipulations, aggravation of pre-existing symptoms.

Notice to All Pregnant Women:

All female patients must alert the provider if they have confirmed or suspected pregnancy as some therapies prescribed could present a risk to the pregnancy.

Notice to all Individuals with bleeding disorders, pacemakers and/or cancer:

For your safety it is vital to alert your provider of these conditions.

Naturopathic physicians will only prescribe medications they believe are in the best interest of myself, the patient.

I understand that the US Food and Drug Administration has not approved nutritional, herbal, and homeopathic substances, however these have been widely and safely used in Europe, Asia and the USA for years.

Naturopathic doctors are not psychologists or psychiatrists. Counseling services are provided for support and improved lifestyle strategies. I do not expect naturopathic physicians and/or allied health care providers to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the doctor explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees of services have been made to me concerning the results intended from any treatment provided to me.

By signing below and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand all the above and give my written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and future conditions for which I seek treatment.

Name of Patient (Print): _____

Name of Guardian (Print): _____

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____