Welcome to Flow Natural Medicine & Acupuncture, PLLC; thank you for choosing to create health with us.

NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT

I, ____________________________, hereby authorize Nina Walsh N.D., to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

GENERAL CARE

Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, laboratory, x-ray.
Minor office procedures: e.g., dressing a wound, ear cleansing.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Psychological Counseling
Contraception
Immunization

PHYSICAL MEDICINE

Physical exam: general, musculoskeletal, orthopedic and neurological exams and tests.
Soft tissue manipulation: massage, neuro-muscular technique, muscle energy stretching, visceral manipulation.
Osseous manipulation: of the extremities and spine, traction, craniosacral therapy.
Hydrotherapies: hydrocollator, constitutional hydrotherapy, cryotherapy.
Exercise prescription: stretching and exercise prescription.

I recognize the potential risks and benefits of these procedures as described below:
Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Physical medicine treatments could aggravate pre-existing symptoms, or cause discomfort, pain, infection, burns, nausea, and light headedness.

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 as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Nina Walsh N.D., or any of her personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Date:__________________Signature of Patient____

Signature of Patient Representative or Guardian____

Patient/Doctor Responsibilities, Medical Record Policies and Patient Information

Please take a few minutes to read this information. It contains a few basic business policies and is designed to assist you in your business interactions with the clinic.

PATIENT RIGHTS AND RESPONSIBILITIES

Patients and providers have rights and responsibilities to one another to insure that the best health care services are provided.

- Patients and providers have the right and responsibility to treat one another respectfully.
- Patients have the right to confidentiality when receiving care from providers.
- Patients have the responsibility to supply accurate and complete medical history information to the provider.
- Patients have the right to know that a record will be kept of the health care services provided to them. They may ask to view, obtain a copy, or amend or correct that record. Providers will not disclose a patient's record to others unless directed to do so, in writing, by the patient, or unless the law authorizes or compels them to do so. (RCW 70.02.120)
- Providers have the responsibility to inform patients about their health condition and include the patient in decisions affecting their care.
- Patients have the right to bring questions, concerns, complaints or compliments about any aspect of one's care or service to the individual provider, their health plan or provider network.
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MEDICAL RECORDS

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 myself, or my representative, or unless it is 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. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered to the best of my practitioner's ability.

Please be aware that we are unable to provide medical records, including lab results, on a walk-in basis. In all cases a medical records release form must be filled out, including patient signature and complete date, in order for us to comply with the law and protect your confidentiality. Requests will be processed and records mailed out within 15 working days. There is no charge for records mailed directly to other health care providers. However, there may be a charge for records released directly to a patient and other agencies.

Notice of Privacy Practices – Acknowledgement

Our **Notice of Privacy Practices** is in a separate document that is a PDF file on website and describes in more detail how your health information may be used and disclosed, and how you can access your information.

This form acknowledging your receipt of our **Notice of Privacy Practices** will be retained in your medical records.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

PARKING & BUSES

Parking is available in the lot in front of the building. For bus route and schedule information, call Metro at 206-553-3000.

Name of patient: Print Name: ____

Signature of Patient:____ Date:______________________

Signature of Patient Representative or Guardian____