Lara Litov, ND *Eastside Integrative Health, PLLC*

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Informed Consent to Naturopathic Care

I, _____, acknowledge that I am accepting treatment from a naturopathic physician. This may include all modalities allowed under the scope of practice of a naturopathic physician licensed in the State of Washington, which include but are not limited to: botanical medicines, vitamins, minerals, prescription drugs, homeopathic medicine, physical medicine, hydrotherapy, exercise instruction and demonstration, nutritional and whole foods therapy and education, health education, physical exams, diagnostic procedures and testing, stress management, and lifestyle and psychological counseling.

I understand that although naturopaths are primary-care providers in the State of Washington, they have some restrictions to their scope of practice, such as limitations in prescriptive authority and lack of hospital privileges, and that in some situations, I may need to be referred to other appropriate providers or settings including hospitals, other primary providers, urgent care facilities, or specialists to obtain necessary or recommended medical care.

I acknowledge and understand that there are inherent risks in any medical treatments, not excepting naturopathic treatments, and as such I choose willingly to undergo this treatment, acknowledging that:

- It is my obligation to inform the provider as soon as possible of any negative side effects of the treatment, which can include but are not limited to: herb, homeopathic, nutrient, and drug reactions or negative interactions, allergic reactions to any substance or treatment, discomfort from physical therapy or aggravation of symptoms.

- It is imperative for proper and safe treatment that I inform all of my providers, including my naturopathic physician, of any treatments or medications I am using, conditions I have, or substances I am abusing; these all have the potential of interacting with one another and having an adverse effect. It is also important that I inform my provider if I am pregnant or nursing as some treatments are contraindicated/potentially harmful in these situations.

- I do not expect the provider to anticipate and explain all potential risks and complications associated with the treatments. I choose to rely on the provider's judgment to determine a course of action based on the facts known to her at the time. I understand that I can and am encouraged to ask any questions and share any concerns with the provider throughout my treatment and that I have the right to refuse any recommended procedure, test, treatment, or referral. It is my right and obligation to inform the provider if I feel uncomfortable with or don't understand any procedure, test, referral, or treatment.

- As with any medical care and treatment, there is no guarantee that this treatment will offer complete resolution to any or all conditions that I may have. I also understand that compliance with treatment will improve the effectiveness of the treatment.

_____ _____

Patient Signature *Date*

_____ _____

Parent/Guardian Signature *Date*