Natural Medicine of Denver
Rachelle Forsberg, ND, LAc

Consent for Naturopathic Medical Treatment

Please Read & Sign

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

General Diagnostic Procedures: including but not limited to venipuncture blood draws, pap smears, general physical exams, and urine assessments.

Lifestyle Coaching & Psychological Counseling & Exercise Prescription

Herbs and Natural Medicines: including but not limited to the prescription of various therapeutic substances including vitamins, minerals, homeopathic (very dilute), plants, minerals, animal materials, and other natural substances in the form of teas, pills, powders, tinctures (may contain alcohol), injections, topical crèmes, suppositories, and other forms.

Therapeutic Nutrition Advice: use of foods, diet plans, and nutritional supplements (oral and injection)

Soft Tissue and Osseous Manipulation: use of massage, craniosacral, traction, neuro-muscular techniques, stretching, visceral/organ manipulation, and manipulation of bones including the head, arms, legs, and spine.

Electromagnetic and Thermal Therapies: use of ultrasound, electrical muscle stimulation, and warming via diathermy/infrared/ultraviolet lights, and hydrotherapies (use of hot and cold water)

Potential Risks: pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury, allergic reactions, soft tissue or boney injury, and aggravation of pre-existing conditions.

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 present additional risks to pregnant women.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue treatment at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that Dr. Rachelle Forsberg has given no guarantees to me.

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Print Patient Name *Patient Signature* *Date*

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Print name of Person responsible if other than Patient *Relationship* *Signature* *Date*

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have been notified of Dr. Rachelle Forsberg's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Dr. Forsberg has the right to change this notice at any time. We will provide a copy of the HIPPA NOTICE PRIVACY PRACTICES at your request.

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Signature of Patient or Parent/Guardian *Date*