

## **Informed Consent to Naturopathic, Chiropractic and Acupuncture Care**

I hereby request and consent to the performance of chiropractic procedures (including various modes of physical therapy and diagnostic testing/examination or to the performance of acupuncture (including needle puncture, point injection, cupping and infrared therapy) or to the performance of naturopathic procedures (including examination, diagnostic testing and the use of natural substances such as vitamins, minerals, botanical medicines and prescription drugs) on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic or naturopathic medicine or licensed acupuncturists named below.

I have had an opportunity to discuss with the doctor of chiropractic, doctor of naturopathic medicine or licensed acupuncturists named below and/or with other office or clinic personnel the nature and purpose of chiropractic care, naturopathic medical care or acupuncture and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, naturopathic medicine and acupuncture these are some risks to the exam and treatment including, but not limited to:  
Chiropractic- fractures, disc injuries, strokes, dislocations and sprains  
Naturopathic Medicine- drug side effects, nutrient-drug interaction and herb-drug interactions  
Acupuncture- bruising, organ puncture, infection, local tenderness, drowsiness

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, supplements, prescribed medications, prescribed exercises and lifestyle modification will increase the effectiveness of my care and enhance or maintain the results. I understand a referral to another physician or specialist may be necessary due to the nature of my condition and limitations in the scope of practice of Naturopathic Medicine, Chiropractic and Acupuncture.

I am aware that Naturopathic Physicians are considered primary care providers in the state of Washington. I acknowledge that the scope of practice of a Naturopathic physician has limitations including limited prescription privileges and lack of hospital privileges. Consequently a referral to a specialist or emergency room may be deemed necessary under certain circumstances and in my best interest.

Furthermore, I understand that some techniques such as neuromuscular reeducation or myofascial release may involve working on muscles located near the breasts, buttock and groin. The doctor will exercise care in keeping sensitive areas drapes during such procedures and if at any time either before or during the treatment I am uncomfortable with work in these areas I will verbally inform the doctor and a written note will be documented in my chart and signed by myself, the doctor and a witness.

I **do / do not** (circle and initial) \_\_\_\_\_ give consent to have photographs taken of my face before, during or after cosmetic acupuncture procedures for educational and/ or marketing purposes.

I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to be able to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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**To be completed by patient:**

**If patient is a MINOR  
To be completed by patient's legal guardian**

\_\_\_\_\_  
PRINT Patient's Name

\_\_\_\_\_  
PRINT Patient's Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Patient's Guardian

\_\_\_\_\_  
Date signed

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**To be completed by doctor or staff:**  
Evergreen Integrative Medicine, LLP  
N.D., LAc

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**Name of doctor(s) treating this patient:**  
Trina Seligman, N.D., LAc / Geoff Lecovin, D.C.,

\_\_\_\_\_  
Witness to Patients Signature

\_\_\_\_\_  
Date