Informed Consent for Naturopathic Treatment

Dr. Andrea Bull, BSc., B.Ed., N.D.

Naturopathic Doctors are required to obtain informed consent and to make sure you are aware of possible side effects/risks due to treatment.

Andrea Bull, ND uses the following modalities in her practice and may be used throughout the course of treatment. Treatment modalities include diet and nutritional counseling, traditional Chinese medicine and acupuncture, botanical medicine, hydrotherapy, massage, homeopathy, Bowen therapy and lifestyle counseling.

During your initial visit, your Naturopathic Doctor will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take urine samples for further testing.

Even the gentlest of therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those taking multiple medications. Some therapies must be used with caution in certain diseases in including but not limited to diabetes, heart/liver/kidney disease as well as any medications (prescriptions or over-the-counter). If you are pregnant or suspect you are pregnant or you are breast-feeding, advise your doctor immediately.

Risks associated with Naturopathic Medicine include but are not limited to:

- aggravation of pre-existing symptoms
- allergic reactions to supplements or herbs
- pain/bruising/injury from acupuncture
- fainting or puncturing or an organ with acupuncture needles.

Recommended Therapeutic and/or Diagnostic Procedure(s)/Plan

(including those by referral to another practitioner)

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I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic procedure(s)/plan and have discussed to my satisfaction this and any requests for related information with Dr. Andrea Bull, ND., I further acknowledge and confirm that I have been informed of and understand the therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having/following the procedure(s)/plan, and what alternative course(s) of action are available to me

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As a result, I do hereby voluntarily consent/withhold/my informed consent for the recommended therapeutic procedure(s)/plan as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

Patient or Lawful Representative Signature

Date Signed

Witness Signature**

***Witness signature is advised but not necessary**

Witness Relation to Patient

Attending ND

Change to Informed Consent

I do hereby voluntarily consent/withhold/withdraw my informed consent for recommended therapeutic procedure (s)/plan as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

Patient or Lawful Representative Signature

Date Signed

Witness Signature*

***Witness signature is advised but not necessary**

Witness Relation to Patient

Attending ND