Dr. Jo Turner, NMD
Dr. Joanne Feaster, NMD
Patient Informed Consent Form

A Naturopathic Medical Doctor uses natural therapies and medication for the purpose of treatment and prevention of illness and disease.
A case history will be taken, and physical examinations, including the testing of blood and urine may be necessary. Other complaint oriented physical examinations/testing may be necessary. Naturopathic treatment includes acupuncture, hydrotherapy, far infrared sauna, homeopathy, massage, manipulation, nutritional intervention, botanical prescription, medication, parenteral therapy (IV, IM, intradermal, subcutaneous), chelation, minor surgery and physical therapy.

Informing your doctor of any disease process which you are suffering from and any medications/over the counter drugs which you are currently taking or have taken is very important. Please advise your doctor immediately: if you are pregnant, suspect you are pregnant or if you are breast-feeding.
As a patient, you will receive information about your diagnosis and/or treatment, alternative courses of action, the material costs, expected benefits, risks, side effects, and in each case the consequences of not having the diagnosis and/or treatment and alternative courses of action acted upon.

There are some health risks associated with treatment by naturopathic medicine. These may include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs or medications, including IV therapeutics
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy or minor surgery
- Possibility of accidental death as a result of intravenous therapy or chelation
- Fainting, or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa, localized reddening of the skin or bruising from cupping
- Muscular pain, strains and sprains, disc injuries from manipulation
- The potential for stroke is a concern with neck (cervical) manipulation

I understand; Please initial each item below.

1. _____ 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 law requires it or I give my written consent. I realize that in rare instances courts may subpoena my medical records, which means that my records will have to be released.

2. _____ The physician will have to report me in the following instances: when I am in imminent danger of harming myself or others, when there is reasonable suspicion that I am neglecting and/or emotionally, physically, or sexually abusing a minor.

3. _____ I may access my medical records at any time, and can request a copy, by doing so in advance and by paying the appropriate fee.

4. _____ The clinic does not guarantee treatment results. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

5. _____ The clinic is not responsible or liable for any referrals to other doctors, lawyers or laboratories.

6. _____ I am responsible for payment of services rendered if not covered by my insurance policy and any fees incurred during the collection of this payment.

7. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Premier Wellness Center.

8. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

9. _____ I hereby assign all benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Natural Choice Medical Care or AZ Naturopathic Health.

10._____ I understand that according to malpractice Insurance and HIPAA rules it is prohibited to review laboratory or imaging results over the phone or email and therefore a follow up appointment will be necessary for the doctor to review such results.

I recognize that this consent form covers the entire course of my treatment.
With this consent, I have the knowledge that I have the right to refuse treatment, or discontinue treatment at any time, for any reason, should I choose to do so.
I have read this statement and agree to work within its guidelines, including the limits of confidentiality.

Please PRINT Patient Name: _____

Signature of PATIENT or Guardian: _____ Date:_____