PACIFIC NATUROPATHIC
MEDICAL CENTER

I, _____, hereby authorize the physician of the Pacific Natural Medical Centre to perform, with my approval and consent, the following procedures to facilitate my diagnosis and treatment:

- **Common Diagnostic Procedures:** Venipuncture, laboratory, X-ray, radiography, etc.
- **Minor Office Procedures:** Wound dressing, ear cleansing and wart treatment, etc.
- **Medicinal Use of Nutrition:** Therapeutic nutrition, nutritional supplements, intra-muscular and intravenous/mineral injections, etc.
- **Physical Medicine:** Therapeutic ultrasound and electrical muscle stimulation, muscle stretching/massage, etc.
- **Botanic Medicine:** Botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories, etc.
- **Homeopathic Medicine:** The use of highly dilute quantities of naturally occurring plants, animals and minerals to stimulate the body's healing responses, etc.
- **Natural Bio-identical Hormones**
- **Chelation:** (Non-IV) Detoxification, heavy metal detoxifications, etc.
- **Lifestyle Counseling and Hygiene:** Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities

I recognize the potential risks and benefits of these procedures as described below:

- **Potential Risk:** Allergic reactions to prescribed herbs, supplements and medications, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or other procedures.
- **Potential Benefits:** Restoration of health and the body's maximum functional capacity relief of pain and symptoms of disease, assistance in injury and disease recover and prevention of disease of its progression.
- **Notice to Women:** All female patients must inform the doctor if they know, suspect or may be pregnant as some of the therapies used could cause present risk to the pregnancy and fetus.

1353 Shell Beach Road, Pismo Beach, CA. 93449
Phone (805) 473-7311 Fax (805) 473-7879
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With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Pacific Natural Medical Centre or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand the Pacific Natural Medical Centre will keep a record of the record of the health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself of my representative in writing or unless it is required by law. I understand that I may look at my medical record and can request a copy of it by paying the appropriate fee. I understand that my medical record will not be kept more than seven years after the last day of my treatment. I understand that any questions concerning this form can be asked of the doctor.

_____ _____

Signature of Patient Date

_____

Signature of Representative or Guardian

Original: Chart
Copy: Patient

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