

## Informed Consent to Naturopathic Treatment

Naturopathic doctors are primary health care practitioners who specialize in natural medicine. Naturopathic medicine focuses on whole-patient wellness. The medicine is tailored to the patient and emphasizes prevention and self-care. Naturopathic medicine attempts to find the underlying cause of the patient's condition in addition to treating the patient's symptoms. The therapies available to a naturopathic patient include dietary and lifestyle counseling, botanical or herbal medicine, homeopathic medicine, vitamin and nutrient supplementation, hydrotherapy, and physical medicine including massage craniosacral therapies. Naturopathic doctors work with all other branches of medical science, referring patients to medical doctors, specialists, and other practitioners when appropriate.

I, \_\_\_\_\_, understand that Dr. Julie Neal, ND, CMT, will answer any questions to the best of her ability. As with any medical treatment, I understand that treatment outcome is variable. I also understand that the likelihood of physical change is dependent on adherence to my individualized treatment plan.

By signing this consent form, I, \_\_\_\_\_ (print name), request and consent to naturopathic care, including various modes of treatment and diagnostic procedures. I understand that naturopathic physicians are not licensed in the state of Colorado, and that Dr. Julie Neal, ND, CMT, is licensed in the state of Washington where she graduated from Bastyr University, a 4-year naturopathic medical school. I also understand that she has passed examination boards required for her medical license. (Initial) \_\_\_\_\_

I have had the opportunity to discuss with Dr. Julie Neal, ND, CMT, the nature and purpose of naturopathic medicine and I hereby consent to naturopathic treatment by Dr. Julie Neal, ND, CMT. (Initial) \_\_\_\_\_

A record will be kept of health services provided to you. This record is confidential and will not be released to anyone without your written consent or legal documentation.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Name: (please print) \_\_\_\_\_  
Guardian Signature: (if patient is under 18 years old) \_\_\_\_\_  
Guardian Name: (please print) \_\_\_\_\_