Transformational Health
transform your life

12727 NE 20th St, Suite 20, Bellevue, WA 98005
Business: (425) 996-8600; Facsimile: (425) 274-4970
Email: drsedmak@transformational-health.com
Wepage: http://www.transformational-health.com

INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the private practitioners to perform the following specific procedures and necessary to facilitate my diagnosis and treatment:

- **Common Diagnostic Procedures**: e.g. Pap smears, etc.
- **Lifestyle Counseling and Hygiene**: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities
- **Medicinal Use of Nutrition**: therapeutic nutrition, nutritional supplementation, intramuscular vitamins, minerals, herbs, homeopathics, etc.
- **Botanical Medicine**: botanical substances may be prescribed as teas, alcoholic or glycerin tinctures, capsules, tablets, creams, plasters, suppositories or solid extracts
- **Homeopathic Medicine**: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing response
- **Physical Medicine**: soft tissue manipulation, osseous manipulation, electrotherapies, ultrasound, hydrotherapies, hyperthermia
- **Controlled substances**: e.g. birth control pills, other hormones, antibiotics, etc.

I recognize that these procedures are considered standard of care in the naturopathic medicine community. However, the conventional allopathic medicine community may find these procedures experimental. I recognize the potential risks and benefits of these procedures as described below.

- **Potential Benefits**: restoration of health, relief of pain and symptoms of disease, assistance in injury and disease recovery, prevention of disease or its progression, less reliance on medication or prescription drugs, increased energy and productivity, increased mental clarity, emotional balance, increased sense of well being
- **Potential Risks**: allergic reactions to prescribed herbs and supplements, side effects of natural medicines, inconvenience of lifestyle changes, injury from injections procedures
- **Notice to Pregnant Women**: all female patients must alert the doctor if they know or suspect that they are pregnant as some therapies used could present a risk to the pregnancy

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the physicians or their staff regarding the 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 that 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 so directed by myself, or my representative, or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but not more than ten years after the date of my last visit. I understand that information from my medical record may be kept and analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner to the best of his/her ability will answer any questions I have.

Date: _____ Signature of Patient: _____

Printed name of Patient: _____

Signature of Patient Representative or Guardian: _____

Printed name of Patient Rep or Guardian: _____