Metamorphe Health Clinic
3976 E. Harbor Road
Langley, WA 98260
360-221-2050

Mailing address:
P. O. Box 1072
Freeland, WA 98249

INFORMED CONSENT FOR TREATMENT

I, _____ Hereby authorize my practitioner of the Metamorphe Health Clinic, In accordance with his/her scope of practice, to perform the following procedures as necessary to facilitate my diagnosis and treatment.

Common Diagnostic Procedures: e.g., venipuncture, Pap smears, radiography, laboratory, x-ray.

Minor Office Procedures: e.g., ear cleansing, dressing a wound, sutures, biopsies.

Naturopathic Manipulation: osseus and tissue adjustments manually or by instrument assisted technique.

Physical Medicine: massage, stretching, exercises, mobilizations, contrast water or heat treatments, halotherapy, etc.

Medicinal Use of Nutrition: therapeutic nutrition, nutritional supplementation, and vitamin injections.

Botanical Medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, creams, etc.

Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Lifestyle Counseling & Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balance of work and social activities.

Psychological Counseling and Biofeedback: improved lifestyle strategies and wellness.

I recognize that I have a right to be informed about my condition(s) and recommended care. This waiver is to help me become better informed so I may give, or withhold, my consent after having the opportunity to discuss my condition, potential benefits, risks, side effects and hazards involved, likelihood of success, alternative treatment options and potential consequences if treatment or advice is not followed and/or nothing is done. I recognize the potential risks and benefits of these procedures as described below:

Potential risks and benefits: risks being, allergic reactions to prescribed medications, herbs and supplements, side effects of natural medications, interactions with certain allopathic medications, inconvenience of lifestyle changes, injury from injections, venipuncture, procedures.

Potential benefits are: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that my practitioner cannot anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise judgment during any of the above procedures and in recommending dietary supplements and other treatments for my condition(s). By signing below, I acknowledge that I have been provided ample opportunity to read, or have been read, this form and had any questions answered. I agree to use this consent form to cover the entire course of treatment for my present condition and for any future condition(s) I seek treatment for. I also understand that I am free to withdraw my consent and to discontinue participation 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 or for insurance claim processing reasons. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical record will be kept for no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

Print Patient's name: _____

Signature of patient: _____Date: _____

Print Guardian's name: _____

Signature of Guardian: _____Date: _____