

Consent Agreement

Dr. Colin Huska, ND

Mutual Understanding and Consent to Treatment

The following information is provided to enable our sharing of a common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agreed to the following.

- Information revealed during counseling and discussion sessions is strictly confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor: Your record and the information within will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- Naturopathic medical treatments are in no way meant to replace conventional medical care or care from another licensed health practitioner. Please let your naturopathic doctor know if you are being treated by other health care providers. It is your responsibility to disclose changes in your condition, symptoms, contact information or treatments between visits.
- Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunction and the use of natural therapeutics for their correction. This may include: physical examination, nutrition, supplementation, homeopathy, botanical medicine, acupuncture/traditional Chinese medicine, hydrotherapy, detoxification techniques, bodywork, counseling, and lifestyle modifications. If at any time the patient wishes to discontinue a particular therapy/treatment they are free to do so.
- The treatment plan will be explained to you, as well as potential side effects of any therapies. You are encouraged to ask any questions you may have. As with any form of medicine, we cannot guarantee the outcome of any treatment offered.
- If you have a serious health problem that requires immediate attention, call your other doctor(s), call 911 or have someone take you to the emergency room. If you notice an adverse effect from one of the components of your health plan, discontinue it and call your doctor and the naturopathic clinic to inform them of what has occurred.
- I agree to pay my full account at the time of each visit for services, cost of supplements/remedies, lab tests or other fees. I am aware that said fees are not covered by MSI.
- CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24-hours notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for missed sessions without such notification.
- The contact information, health history, and other information that I provided on my intake form are complete and accurate.

I (print name) _____ understand and agree to the information on this page and give my consent to treatment. My questions, if any, were answered to my satisfaction.

SIGNATURE of patient or guardian

Date