Suzanne Ho-Miecznikowski, B.Sc., N.D.
naturopathic doctor

CONSENT TO NATUROPATHIC TREATMENT

Patient name ____

Each person must sign this document before any treatment will be rendered.

My signature acknowledges that I have been informed and understand that:

i) The treatments that I receive in this office are different from those usually offered by a medical doctor or other licensed health care practitioner.

ii) I am at liberty to seek or continue to seek medical care from a physician or surgeon or other health care practitioner qualified to practice in Ontario.

iii) I have received a complete explanation of the diagnostic or treatment protocols that I may receive at this office and hereby authorize and consent to treatment.

iv) I acknowledge that Suzanne Ho-Miecznikowski, ND endeavours to provide the best possible diagnosis and course of treatment, but that no warranty is made with respect to any treatment, action, or medical advice given, as many factors will be important in determining actual results.

v) I have been informed of (with respect to diagnostic and treatment procedures) financial costs, expected benefits, potential risks and side effects, likely consequences of not following the treatment plan, and what alternative course(s) of action are available to me.

vi) I agree to pay the fees for each visit or treatment, on the day of the treatment. I am aware that these fees are not covered by OHIP.

I do hereby voluntarily give my informed consent for Dr. Suzanne Ho-Miecznikowski, ND to administer recommended diagnostic and therapeutic procedures. I also understand that I may change the status of my voluntary informed consent at any time.

______________________________ ______________________________
Patient Signature Date

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