NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT

I, _____________________________, hereby authorize Stephany L. Porter, ND and Elise Benczkowski, ND to perform the following specific procedures as necessary to facilitate my treatment:

Physical Exam: e.g., general, musculoskeletal, cardiovascular, abdominal, respiratory.
Medicinal Use of Nutrition: therapeutic nutrition, nutritional supplements.
Botanical Medicine: botanical substances may be prescribed as teas, alcohol-based tinctures, capsules, tablets, creams, plasters, or suppositories.
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 and Hygiene: nutrition therapy and promotion of wellness, including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Psychological Counseling
Contraception
Hydrotherapy
Cranial Sacral
Detoxification

I recognize the Potential Risks and Benefits of these Procedures as described below:

Potential Risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, or injury from procedures.

Potential Benefits: restoration of health and the body’s maximum 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 Dr. Porter or Dr. Benczkowski if they know or suspect that they are pregnant, could become pregnant, or are nursing to ensure that remedies are not used that could present a risk.

Nature of Services: A naturopathic doctor is not a medical doctor and naturopathy is not a medical specialty but a separate and distinct health care tradition. Dr. Porter and Dr. Benczkowski graduated from an accredited four year residential graduate program and are licensed in Maryland as naturopathic doctors. The scope of practice is limited to specific practices set forth in Health Occupations Article, Section 14-5F-14. This scope includes complete physical examination, laboratory and physiologic testing and the ordering of diagnostic imaging but does not include prescribing, administering or injecting drugs, surgery or high-velocity osteopathic/chiropractic adjustments. I understand that my naturopathic doctor does not replace the service of my primary care physician.

Naturopathic medicine is not intended to substitute for diagnosis or treatment by medical physicians or used as an alternative to necessary medical care, and a patient should not avoid any diagnostic work-up suggested by your medical physician as a result of naturopathic diagnosis or treatment. If a patient wishes to discontinue or avoid any medical treatment in favor of naturopathic care, this should be discussed with both Dr. Porter or Dr. Benczkowski and the treating physician. Patients are encouraged to have a primary care physician in place familiar with their medical history.

After the initial intake and on an ongoing basis, Dr. Porter and Dr. Benczkowski will explain their assessment and describe the nature of the recommendations, expected health progress, and the anticipated costs, risks, benefits and experience of following various options. The focus of naturopathic care is to alleviate the underlying conditions that bring about illness rather than the treatment of symptoms. While patients may experience some immediate improvement from the use of supplements, herbs, homeopathic remedies or other botanical and naturopathic methods, the most effective results occur when clients make a long-term commitment to rebuild their health.
Emergency Notice: The Bodhi Clinic does not offer after hour services or provide any hospital-based services. If difficulty occurs with any of remedies or other aspects of naturopathic work, patients should contact her during business hours to discuss any concerns. In the event of an emergency, patients should contact 911 or their primary care physician as needed.

Insurance Notice/Financial Responsibility: Naturopathic medicine is not a covered service or recognized by Medicare, private insurance, or other third-party payors. Reimbursement is not usually available for these services. Fees can be paid from the patient’s FSA or HSA medical savings accounts. Patients are financially responsible for payment at the time of service. In the event, I have a balance on my account that exceeds 30 days, I agree to pay interest at an annual rate of 12% and pay reasonable attorney’s fees and costs for collection.

Cancellation Policy: Notice of appointment cancellations or a request to reschedule must be received 24 hours prior to an appointment. If your appointment is scheduled for a Monday, you must contact us by 12:00 noon the Thursday before. The fee for an appointment that is not cancelled with sufficient notice is $50-150.

Informed Consent for Naturopathic Consultation

I have read and understood the foregoing and hereby authorize naturopathic medical assessment and treatment by Dr. Porter and Dr. Benczkowski. I understand the nature of this health care method including the potential risks of possible adverse reactions to products that may be suggested, and which I chose to take, over the course of naturopathic care and that both treating doctors are not medical physicians. I agree to assume the risks of care, whether known or unknown. I understand and agree to the above stated office policies and the financial agreement.

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 my representative or myself, or unless required by law. I understand that I may look at my medical record 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 years, but no more than ten years after the date of my last visit. I understand that full disclosure of information has been made to me and all my questions have been answered to my full satisfaction.

________________________  _________________________
Date                                Signature of Patient or Legal Guardian

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Printed Name