For the Practice of Melissa Sophia Joy, ND

# INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of naturopathic treatments and other procedures within the scope of the practice of naturopathic medicine on my (or on the patient named below, for I am legally responsible for) by the naturopathic doctor named below and/or other licensed naturopathic doctors who or in the future treat me while employed by, working or associated with or serving as back-up for the naturopathic doctor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: botanical medicine, nutritional counseling, essential oils, flower essences, homeopathy, medical intuitive counseling, hypnotherapy, mind-body counseling, Theta Healing®, Somatic Awakening®, Reichian breathwork, Voice Dialogue, energy medicine (Intuition Medicine®, reiki, polarity, craniosacral, etc.) Sound Therapy, Channeling, and massage. I understand that the herbs, remedies and supplements should be consumed according to the instructions provided orally and in writing. I will immediately notify the naturopathic doctor listed below of any unanticipated or unpleasant effects associated with the herbs, remedies or supplements.

I have been informed that naturopathic medicine is a generally safe method of treatment, but that it may have some side effects, such as a healing crisis which could cause fatigue, nausea, muscle soreness, headache, etc. The herbs, remedies and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe, although some may be toxic in large doses or have unintended side effects. I understand that some herbs and supplements may be inappropriate during pregnancy or breastfeeding. **I will immediately notify the naturopathic doctor who is caring for me if I am or become pregnant or am currently breastfeeding.**

I do not expect the naturopathic doctor to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the naturopathic doctor to exercise judgment during the course of treatment which the naturopathic doctor thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. I also understand that staff will be receiving voicemails left on the office phone and that they are not confidential. Also, I understand that communication via email is not always reliably confidential. However, voicemail communications via the naturopathic doctor's personal cell phone voicemail is confidential.

I understand that payment is expected at the end of each session and if I have a phone or Zoom session that it needs to be pre-paid in advance of the session. **I understand that all pre-paid series are non-refundable and are only valid within six-months of purchasing the series. I also understand that Dr. Joy has a 48-hour cancellation policy that is enforced with situations that are non-emergencies or are not communicated to the doctor within 48-hours after the scheduled appointment time.** Please note that the 48-hour cancellation policy does not include weekends since we are not in the office during that time.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, understand the risks and benefits of naturopathic medicine and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

**By typing or signing my name below, I acknowledge that I have read, understood, and agree to the terms outlined in this document.**

I affirm that my typed or handwritten signature represents my legal and binding agreement to these terms, consistent with the U.S. Electronic Signatures in Global and National Commerce Act (E-SIGN Act) and the Uniform Electronic Transactions Act (UETA).

☐ **By checking this box, I acknowledge that I have read, understood, and agree to the terms outlined in this document. By typing my name below, I am signing this waiver electronically.**

Date: _____

Client Signature : _____

Client Name (printed): _____
(Indicate relationship if signing on behalf of patient)