**Transformational Medicine, PLLC**
**Dr DeeAnn G Saber, NMD**
**3861 North First Avenue**
**Tucson, Arizona 85719**
**520-209-1755**

## *Informed Consent and Request for Naturopathic Treatment*

**I, as a patient, have the right to be informed about my condition and recommended care. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care, having had the opportunity to discuss the potential benefits, risks, and hazards involved.**

I hereby request and consent (or for the patient for whom I am legally responsible) to examination and treatment with Naturopathic Medicine by Dr. DeeAnn G. Saber, at the office, who now or in the future may treat me while working, at Transformational Medicine, 3861 N First Ave. Tucson, AZ 85719.

**I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Saber, NMD:**

1) My suspected diagnosis or condition;
2) The nature, purpose and potential benefits of the proposed care;
3) The inherent risks, complications, potential hazards, or side effects of treatments or procedures;
4) The probability or likelihood of success;
5) Reasonable available alternatives to the proposed treatments or procedures;
6) The possible consequences if treatment or advice is not followed and/or nothing is done.

**I understand that naturopathic evaluation and treatment may include, but is not limited to:**

*Physical exam (general, musculoskeletal, orthopedic, and neurological assessments);

*Common diagnostic procedures (venipuncture, pap smears, diagnostic imaging, laboratory evaluation of the blood, urine, stool, and saliva);

*Soft tissue and osseous manipulation (massage, neuromuscular technique, muscle energy stretching, cranio-sacral therapy, osseous manipulation of the extremities and spine);

*Electromagnetic and thermal therapies (ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrode stimulation, and infrared and ultraviolet therapies);

*Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements, and intramuscular vitamin injections);

*Herbs/natural medicines (prescribing of various therapeutic substances including plants, mineral and animal materials.) Substances may be given in the forms of teas, pills, creams, powders, tinctures, suppositories which may contain alcohol, topical creams, pastes, plasters, washes or other forms.

*Homeopathic remedies (often highly diluted quantities of naturally-occurring substances);

*Hydrotherapy (use of hot and cold water, colon hydrotherapy, cryotherapy);

*Counseling (including, but not limited to, biofeedback, hypnosis, and visualization for improved lifestyle strategies and wellness);

*Over the counter and prescription medications (including only medications approved by the Department of Health).

**I understand and I am informed that in the practice of Naturopathic Medicine that there are some risks and benefits with evaluation and treatment including, but not limited to the following:**

**Potential Risks:** Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies, allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; an aggravation of pre-existing symptoms; emotional response from somatic or other therapies.

**Potential Benefits:** Restoration of the body's maximal functioning 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 provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. The treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such treatment.

**Notice to individuals with bleeding disorders, pace makers, and cancer:** For your safety, it is important to alert the provider of these conditions.

**Please indicate that you have read and understand the following by initialing next to each.**

**_____I understand that Dr. Saber will only prescribe medications if she thinks that it is in the best interest of the patient. Appropriate referrals will be provided to manage prescriptive medication needs of patients.**

**_____I understand that the US Food and Drug Administration has not approved nutritional, herbal, and homeopathic substances; however, they have been widely used in Europe, China, and the USA for years.**

**_____I understand that Dr. Saber is not a psychologist or psychiatrist. Counseling services are for the improvement of lifestyle strategies and wellness.**

**_____I acknowledge that I am responsible for all services provided. I understand this is a cash based practice and that payment is due each visit. I can get a bill and submit it to my insurance but this does not imply any reimbursement will be forthcoming.**

I do not expect Dr. Saber and/or any allied health care providers to be able to anticipate and explain all risks and complications, but I wish to rely on the provider to exercise best judgment during the course of the assessment and treatment, based on the known facts. I also understand that it is my responsibility to request that the provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand the above and have given my oral and written consent to evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

Print patient's name

Signature of patient Date Signed

Print name of patient's guardian

Signature of patient's guardian Date Signed