Naturopathic medicine is the treatment and prevention of diseases by natural means. Your Naturopathic Doctor will take a thorough case history, which may include a complete or partial screening physical examination. It is very important that you disclose to your Naturopathic Doctor of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

There are some slight health risks to treatment by naturopathic medicine. These are rare, but include, and are not limited to:

- Possible aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.
- Muscle strains and sprains, disc injures from spinal manipulation.

Statement of Acknowledgement (please initial consent where indicated)

As a patient of Dr. Julie Zepp Rutledge, I [print name]_____ :

- Have read and understood the rare but potential risks associated with Naturopathic Medical Care. [initial]_____ With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: _____.
- 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 myself in writing or unless law requires it. [initial]_____
- Understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. [initial]_____
- Understand that in order to enhance the quality of care provided to me, my case may be discussed among the naturopathic doctors within the Cathedral Centre for Wellness (Drs Geis, Stark, Zepp Rutledge, and Ziegler). My identity will be protected and kept confidential. [initial]_____
- Should I receive services from more than one naturopathic doctor within the Cathedral Centre for Wellness, I understand that my file may be shared between your doctors unless other arrangements are discussed and agreed upon. [initial]_____
- Understand that information from my medical record may be analyzed for research purposes but will exclude any identifying information. [initial]_____
- Certify that the information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs. [initial]_____
- I intend this consent form to cover the entire course of treatment for any health condition I may seek assistance for. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. [initial]_____
- I take responsibility to inform my naturopathic doctor of changes that may affect my treatment plan (ie, addition of a new medication or supplement, change in symptoms, an injury or surgical procedure, etc.)
- I accept full responsibility for any fees incurred during care and treatment. [initial]_____

Patient Name (please print): _____

Guardian or Parent Name (if patient is under 16): _____

Signature(of patient or guardian/ parent: _____

Date: _____