LORRAINE CARUSO, ND
DOCTOR OF NATUROPATHIC MEDICINE

THE REGENT HEALTH CENTRE
150 LOCKE STREET SOUTH
HAMILTON, ON L8P 4A9 TEL: 905-523-4999

Patient Agreement and Informed Consent

I voluntarily consent to the procedures and treatment by Naturopathic Doctor, Lorraine Caruso, which can include any combination of the following: medical history, physical exam, diagnostic testing, botanical medicine, homeopathy, traditional Chinese medicine, clinical nutrition, hydrotherapy, lifestyle counselling and coaching, supportive counselling, and mind-body medicine, including Phoenix Rising Yoga Therapy.

I understand the following:
My medical records will be kept confidential and will not be released to anyone without my consent, unless required by law or I am risk of harming myself or others. In order to ensure optimal care, Naturopathic Doctors may consult with other professionals about my case. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

Naturopathic Medicine can be used to help prevent and treat illnesses. However, Naturopathic Doctors cannot guarantee results of treatment.

Complications are very rare when treatment by a licensed Naturopathic Doctor. Naturopathic Doctors cannot anticipate all risks and complications associated with treatment; however, they will do they will do their best to inform me of the most common side-effects. I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability

I am responsible for informing the above Naturopathic Doctor if my condition or medications change, or I become pregnant, as treatments may be contraindicated in some conditions.

I agree to pay for charges incurred during each visit by the end of the visit unless alternate arrangements have been made prior to my scheduled appointment. I will be provided with a receipt upon payment so that I can bill my insurance company. I will be charged additional fess for supplements/homeopathic treatments/botanical medicines as well as laboratory testing. I will also be charged for missed appointments, late cancellations (less than 24 hours) and overdue payments.

The clinic will endeavour to collect and maintain accurate personal information about me for the purpose of assessing my health concerns, advising me of my options, providing high quality natural and professional healthcare, maintaining contact with me, facilitating practice management and complying with naturopathic regulations.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Name (please print): _____ DOB: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____