RĒBALANCE, A NATUROPATHIC CLINIC

Helping active people take control of their health

Name:_____ Date of Birth: _____Gender (circle): M / F
Address: _____ City: _____State: ____ Zip: _____

Telephone (home): _(_____)_____ (Work/Cell): _(_____)_____

By circling home or work/cell, please indicate which number we may leave a confidential message.

Email Address: _____

This document is intended to serve as confirmation of informed consent for injection therapy such as superficial or deep injections as ordered by the Naturopathic Doctor at Rebalance, a Naturopathic Clinic.

(Initials) _____ I have informed the doctor of any known allergies to drugs or other substances, or of any past reactions to anesthetics. I have informed the doctor of all current medications and supplements.

I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

I understand that:

1. The procedure involves inserting a needle into various areas of the body and injecting of procaine/lidocane, vitamins and/or other homeopathic remedies.
2. Risks of injection therapies include:

a. Occasionally to commonly:
   i. Discomfort, bruising and pain at the site of injection.
   ii. Fatigue, dizziness, or light-head feeling after the injections.
   iii. Fainting or loss of consciousness during the procedure.

b. Extremely Rarely:
   i. Severe allergic reaction, anaphylaxis, cardiac arrest and death.

I am aware that other unforeseeable complications could occur. The doctor has explained these risks to me as well as other options for treatment including receiving no treatment and the probable outcomes. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

I understand that I have the right to consent to or refuse any proposed treatment at any prior to its performance. My signature on this form affirms that I have given my consent to injection therapy with any different or further procedures which, in the opinion of my doctor, may be indicated.

Signature below confirms that:

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1. I understand the information provided on this form and agree to the foregoing.
2. The procedure(s) set forth above has been adequately explained to me by my doctor.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of the procedure(s).

Patient's Name – Please Print	Patient's Signature	Date

Doctor's Name – Please Print	Doctor's Signature	Date