

**INFORMED CONSENT TO HOMEOPATHIC AND NATUROPATHIC  
TREATMENT AND OFFICE POLICIES**

I (name) \_\_\_\_\_ consent to be treated or for my child  
(name) \_\_\_\_\_ to be treated by Dr. \_\_\_\_\_  
\_\_\_\_\_, a licensed naturopathic physician in the  
State of Washington.

Description of treatment: Homeopathic medicine uses dilute, natural substances to treat the whole person. Naturopathic medicine utilizes various natural therapies including herbs, vitamins and minerals, nutritional recommendations, manipulation, and psychological counseling. Although many scientific studies and years of clinical experience have shown these procedures to be safe and effective, they are still recognized by some individuals and groups as "experimental".

I recognize the potential risks and benefits of homeopathic and naturopathic medicine.

Potential risks: adverse reactions to homeopathic medicines, herbs, vitamins, minerals, nutritional recommendations, manipulation, or other prescribed treatments.

Potential benefits: improved health that may lead to prevention or relief of symptoms and elimination of problems.

Release: Fully understanding the above-described information and potential risks, I voluntarily consent to treatment, realizing that, as with any medical treatment, no guarantees are possible and none have been given to me by my doctor or his/her staff regarding any cure or improvement in my condition. I hereby release Dr. Ullman and Dr. Reichenberg-Ullman's clinic, staff, or on-call physician (in case of emergencies) from any and all liability that may arise as a result of my diagnosis and/or treatment. I understand that any of my questions regarding any procedures will be answered by the doctor and his/her staff and that I am free to withdraw my consent and to discontinue treatment at any time.

Medical records: I authorize the utilization of clinical or other information contained in my medical records for research or teaching purposes so long as my identity is not disclosed. Information regarding my case may be shared with other health professionals or with attorneys, with my permission, to further the goals of my treatment program or for any other appropriate purpose.

Payment: I have been informed about the doctors' fees and acknowledge that I am directly responsible for payment of all charges incurred while I am under the care of Drs. Ullman or Reichenberg-Ullman. I understand that all payments are due at the time of service. I will pay for all pharmacy items and books when I received them. I understand that all payments may be made by check, Visa, or Mastercard, that \$20 will be charged for any returned checks, and that a \$5 handling fee will be added monthly to any outstanding balance not paid within 30 days of service. I realize that your office does not send bills and that I am responsible

for prompt payment of my outstanding balance. I agree to pay for any costs of collection and/or attorney fees or costs incurred by any delinquent unpaid balances on my or my child's account.

Insurance: Regarding insurance reimbursement, I will pay all fees directly to The Northwest Center for Homeopathic Medicine (NCHM) at the time of each visit and, if appropriate, will seek reimbursement from my insurance company with the exception of any carrier that has a contract with the doctors. I must advise the office staff prior to any visits if you are contracted with my insurer. It is my responsibility to know about my deductible, copayment, referrals, dates of coverages, services covered, and reimbursement. I know that phone consultations are rarely covered by insurance.

Cancellations and Missed Appointments: I understand that all appointments cancelled less than 48 hours in advance will be charged at one-half the appointment fee except in case of emergency. Appointments cancelled less than 24 hours in advance as well as no-shows will be charged at the full appointment fee. I am responsible for keeping my appointment whether or not I receive a reminder call. I will call the office to cancel any appointments during office hours or will leave a message on the voicemail when the office is closed. I understand my insurance will not cover any missed appointments. The cancellation policy applies to my first as well as subsequent appointments.

Special Payment: If I am over 65, I qualify for a 10% discount on office visits and will request it. If I have a financial hardship, I may inquire about special arrangements prior to my appointment.

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND AGREE TO ALL OF THE ABOVE PROVISIONS.

\_\_\_\_\_  
(Signature of patient or of person authorized to consent for patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of witness)

\_\_\_\_\_  
(Date)