HUDSON
NATUROPATHIC CLINIC

Consent for Treatment

I hereby authorize **DR. TANYA HUDSON** to perform and/or order procedures that include but may not be limited to the following in order to facilitate my diagnosis and treatment:

General Diagnostic Procedures-including but not limited to pap smears, X-rays, blood and urine laboratory evaluation, allergy testing, and general physical exams.
Psychological Counseling, Lifestyle Counseling, and Exercise Prescriptions
Herbs, Natural, and Allopathic Medicines-prescribing of various therapeutic substances including plant remedies, vitamins and minerals, amino acids, glandulars, and pharmaceutical drugs. Substances may be given in the form of teas, pills, powders, and tinctures that may contain alcohol; topical creams, essential oils, homeopathic remedies, flower essences, and suppositories; other medicines may be used.
Dietary Advice and Therapeutic Nutrition-use of foods, dietary suggestions or nutritional supplements for treatment.
Soft Tissue and Osseous Manipulation-including but not limited to the use of massage, muscle energy stretching, and Cranial Therapy.
Vitamin and other Injections, including HCG for weight loss.

Potential benefits of treatment: Restoration of health and the restoration of optimal function, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Potential risks of any medical treatment: Pain, discomfort, infection, loss of consciousness or deep tissue injury from needle insertions; allergic reactions to prescribed herbs or supplements; and aggravation of pre-existing symptoms. HCG side effects include: headache; feeling restless or irritable; mild swelling or water weight gain; depression; breast tenderness and swelling; and or injection site inflammation and pain. A more concerning side-effect is ovarian hyperstimulation syndrome (OHSS).

Notice to pregnant and breastfeeding patients: All patients who know or suspect that they are pregnant and/or breastfeeding must alert Dr. Hudson, since some of the therapies used could present a risk to the pregnancy and/or breastfeeding infant. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. Some therapies are also contraindicated for breastfeeding women.

Agreement

Dr. Hudson does her utmost to ensure that you receive the most effective care. Because of the quality of care she tries to give her patients, she can only schedule a limited number of patients each day. In consideration of this, she requests that you show up for your appointments on time. If you need to cancel an appointment, please give her 24 hours notice. Without the 24 hours notice, there will be a $50 charge for missed appointments. This will be strictly enforced.

Patient Acknowledgement

I have read and understand the above statement regarding possible treatments and was given the opportunity to have any questions concerning my care answered by Dr. Hudson.
I am aware that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Hudson.
I 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 me or by my representative or otherwise permitted or required by law; however, by signing this form I authorize the release of my confidential health information to other participating providers directly involved in my healthcare.
I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.
I have read, understood, and agree to the terms outlined in this document.
I hereby consent to Naturopathic treatment for myself or my child/dependent.
I understand that I will pay for the services provided my Dr. Hudson and her staff at the time of my appointment, either in full, or according to a payment plan discussed with Dr. Hudson prior to the appointment.
I understand that Dr. Hudson requires a 24 hours notice (not including weekends) if I need to cancel or reschedule an appointment. **There will be a $50 charge for appointments cancelled or rescheduled with less than 24 hours notice.**
I am not here in my function as a government agent.

Signed _____ Date: _____

Print Name:_____
Relationship: Self / Parent / Guardian (*circle*)