

SNOHOMISH VALLEY HOLISTIC MEDICINE

# CONSENT FOR TREATMENT

I hereby authorize Dr. Stacy Bowker, ND to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**General Diagnostic Procedures** (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments)

**Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions**

**Herbs/Natural Medicines** (prescribing of various therapeutic substance including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

**Dietary Advice and Therapeutic Nutrition** (use of foods, diet plans, or nutritional supplements for treatment—may include intramuscular vitamin injections.)

**Soft Tissue and Osseous Manipulation** (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy.)

**Electromagnetic and Thermal Therapies** (includes the use of therapeutic ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and hydrotherapies.)

*Potential Risks:* Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

*Potential Benefits:* Restoration of health and the body’s maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

*Notice to Pregnant Women:* All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used.

I understand that I may ask questions regarding my treatment before signing this form and 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 Snohomish Valley Holistic Medicine, LLC or the providing doctor. 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 a representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request (see *Notice of Privacy Practices*) and that obtaining a copy of my record may require payment of a fee.

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Guardian/personal Representative’s Name (Print)

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Patient’s Name (Print)

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Guardian/personal Representative’s Signature

\_\_\_\_\_  
Patient’s Signature

\_\_\_\_\_  
Relationship/Representative’s Authority

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date