STATEMENT OF ACKNOWLEDGEMENT AND CONSENT TO TREATMENT

Each person seeking naturopathic care at this clinic should understand that Dr. Chris Ford and Dr. Darcie Pawlick are both licensed Naturopathic Doctors (N.D.), not medical doctors (M.D.).

I hereby request and consent to the performance of naturopathic diagnostic procedures and treatments by Dr. Chris Ford and/or Dr. Darcie Pawlick. These procedures include, but are not limited to: taking a thorough case history, performing physical examination, laboratory diagnostic procedures (blood, urine), clinical nutrition and dietary therapy, botanical medicine, Traditional Chinese Medicine and acupuncture, Naturopathic manipulation, intramuscular injections, homeopathy, lifestyle counseling, intravenous therapy, hydrotherapy and pharmacotherapy.

I understand that I am free to refuse any treatment, withdraw my consent or withdraw as a patient at any time.

I understand that any treatment or advice provided to me, by Dr. Chris Ford and/or Dr. Darcie Pawlick, is not being provided to me in the place of, or to the exclusion of, any other treatment or advice that I may now be receiving or, may in the future receive, from a physician, surgeon, or any other licensed health care provider. I also understand that treatment results for any condition are not guaranteed.

I further understand and am informed that, as in all health care, there are some very slight risks to treatment. I understand that Naturopathic medical procedures and supplements may be associated with potential side effects including, but not limited to: aggravation of existing symptoms; allergic reactions; pain, fainting, bruising or injury from venipuncture, acupuncture, intravenous therapy or intramuscular injections; muscle sprain, strain or disc injury from Naturopathic manipulation. I understand that I am encouraged to ask such questions I may have at any time and to advise Dr. Chris Ford and/or Dr. Darcie Pawlick of any unusual symptoms which may or may not be associated with any of the above procedures or supplements. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure and/or treatment to which the doctor feels at the time, based on the facts then known, is in my best interests.

I understand that Dr. Chris Ford and Dr. Darcie Pawlick have a privacy policy that complies with regulations set out in the federal privacy legislation *Personal Information Protection and Electronic Documents Act* (PIPEDA) that applies to the collection, use and disclosure of my personal information. I understand that Dr. Chris Ford and Dr. Darcie Pawlick are both committed to protecting my personal information. I consent to collection, use and disclosure of my personal information, and I understand that I may request a copy of the privacy code and policy at any time.

I acknowledge that I am accepting or rejecting this care of my own free will. I understand that the ultimate responsibility for my health care is my own and that Dr. Chris Ford and/or Dr. Darcie Pawlick is/are here to support me in these efforts. I understand that Dr. Chris Ford and/or Dr. Darcie Pawlick reserves the right to discontinue their services where it is apparent that my expectations and the type of services provided at Roots to Health Family Clinic are not compatible, but will supply me with alternative options.

I understand that all fees for services and supplements are payable in full at the end of the appointment. I hereby agree to pay my account at the conclusion of each and every visit. I also understand that MSP does not cover Naturopathic services (except those on Premium Assistance at $25 per visits for up to 10 visits) and that certain Naturopathic procedures may not be covered under extended medical insurance. I further acknowledge and agree that I will be charged the equivalent fee for all and any missed appointments unless I have advised Dr. Chris Ford and/or Dr. Darcie Pawlick of my cancellation by phone no less than 24 hours in advance of the scheduled appointment.

I am at least sixteen years old and I have read the above statement. I have had an opportunity to ask questions about its content, and by signing below, I agree to the procedures and treatments mentioned above.

I intend for this consent to cover the entire course of treatment for my present condition and for future conditions, for which I may seek the services of Dr. Chris Ford and/or Dr. Darcie Pawlick

OR

I confirm that I am legally authorized to grant consent to have the patient treated by Dr. Chris Ford and/or Dr. Darcie Pawlick.

TO BE COMPLETED BY PATIENT OR LEGALLY AUTHORIZED GUARDIAN:

_____ _____

Print Name Signature of Patient or Legal Guardian

Dated this_____,of_____,_____.

Day Month Year

ROOTS TO HEALTH
NATUROPATHIC CLINIC