



NATURAL HEALING FAMILY MEDICINE

LORI WIESER N.D.
NATUROPATHIC PHYSICIAN

Informed Consent for Treatment

I, _____, Hereby authorize Dr. Lori Wieser to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.

Common diagnostic procedures: venipuncture, Pap smears, radiography, laboratory, x-ray.

Contraception

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

Immunization

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

Medical use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Minor office procedures: dressing a wound, ear cleansing.

Psychological Counseling

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

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 as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Lori Wieser regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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 myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by Dr. Lori Wieser to the best of her ability.

Date

Signature of Patient

Signature of Patient Representative OR Guardian

Location 1: 411 N. 3rd St. Ste. A2 Elma, WA 98541 Phone: 360-402-4943

&

Trinity Massage and Wellness

Location 2: 3700 Martin Way E. #108 Olympia, WA 98506 Phone: 360-561-0171