DR. DEBORAH EPSTEIN
Lumina Health Naturopathic Medicine | www.lumina-health.com | 206.547.1980

INFORMED CONSENT FOR MEDICAL CARE

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by Washington-licensed naturopathic physician Deborah Epstein, ND and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for Dr. Epstein ("the doctor").

I understand that the methods of treatment offered by the doctor are permitted under Washington State law RCW 18.36A. The practice of naturopathic medicine includes practices such as lifestyle and emotional counseling, clinical nutrition and hygiene; the prescription, administration, dispensing, and use (except for the treatment of malignancies) of nutritional supplementation, naturopathic medicines, homeopathy and certain pharmaceuticals and immunizations; physical modalities, manual manipulation, and hydrotherapy; minor office procedures, nondrug contraceptive devices, common diagnostic procedures; stress reduction techniques and suggestion; intramuscular injections, and IV therapy.

I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these range from minor to fatal. I understand that the U.S. Food and Drug Administration has not evaluated or approved nutritional/herbal supplements or homeopathic remedies. I understand that, as with drugs, nutritional/herbal supplements and homeopathic remedies may cause some side effects in sensitive individuals, may interact with prescription medications and other therapeutics such as but not limited to conventional and Chinese medicines or lab tests, or cause symptoms due to pre-existing disease conditions. I agree, for my safety and quality of care, to inform the doctor of other healthcare I am receiving, including but not limited to herbs, medicines, and drugs that I am taking, and to inform the doctor of any changes to my health regimen and/or healthcare providers that I am seeing. The herbs, homeopathic medicines and nutritional supplements that the doctor recommends are considered safe when taken as instructed in the practice of naturopathic medicine. I agree to follow the prescribed recommendations when taking these therapies, because they may be toxic when taken in large doses.

I do not expect the doctor to be able to anticipate and explain all risks and potential complications. I wish to rely on her to exercise judgment in recommending therapies she feels are in my best interest, based on the available knowledge. I have the opportunity to ask questions and discuss with the doctor to my satisfaction: 1) my condition 2) the nature, purpose, and potential benefit of the proposed therapies 3) the material risks inherent in the therapies 4) the probability of those risks occurring 5) the likelihood of success 6) reasonable available alternatives to the proposed therapies 7) the material risks inherent in such alternatives and the probability of such risks occurring 8) the possible consequences if advice is not followed and/or no therapies are undertaken. I recognize that I have the responsibility to indicate when I do not understand to my satisfaction the purpose, risks and benefits of a recommended therapy; and when appointment time has run out, I understand that I have the option of scheduling a follow-up appointment to further discuss my questions.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant or could become pregnant, as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above therapies, and assert that I am legally and mentally capable of giving consent. I realize that no guarantees have been given to me by the doctor or any of her personnel, regarding cure of my condition or any condition. I understand that I am free to withdraw my consent and to discontinue participation in these therapies at any time.

I will promptly inform the doctor if I experience any serious adverse reactions to prescribed therapies, including gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In any event, if an emergency medical condition arises, I agree to seek treatment immediately from a trauma center, or by calling 9-1-1.

Signature: ____ Date: ______________________

Printed Name: ____

Name/Relationship of person signing if patient is unable to, or under 18: ________________________________