

INFORMED CONSENT

I would like to take this opportunity to welcome you to my practice. As a naturopathic doctor, I utilize the principles and practices of Naturopathic Medicine as well as supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means and lifestyle coaching.

As a part of your care I will conduct a thorough case history, perform any necessary physical examination, including a breast exam and take blood and urine samples when necessary. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

Statement of Acknowledgement

As a patient of Dr. Zeynep Uraz, I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information I provide is complete and inclusive of all health concerns including risk of pregnancy or current breast-feeding; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture (blood draw for lab purposes) or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

I understand:

- Treatment results are not guaranteed.
- My naturopathic doctor will explain to me the exact nature of any treatment provided and will answer any questions that I may have.
- I am free to withdraw my consent and to discontinue treatment at any time.

Patient Name (Please print):

Singature of patient (or guardian):

Date:

Signature of ND:
