



## Anita M. Larrow, ND

Bringing Naturopathic Medicine To Your Door

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### Informed Consent And Request For Naturopathic Medicine

I, (Please Print) \_\_\_\_\_, hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as on-call for the above named doctor, whether signatories to this form or not. I have also read and understand the attached NOTICE OF PRIVACY PRACTICES, which discusses my rights under the Health Insurance Portability and Accountability Act of 1996.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act, which may include but are not limited to nutritional counseling, herbs, homeopathy, nutritional supplements, oral chelation, hormone therapy, hydrotherapy, intramuscular injections, and IV therapy.

I understand and I am informed that the evaluation, diagnosis and treatment may include, but is not limited to:

- Interview: history taking, current and past medical history, family history, social and emotional histories, drugs and supplements currently taking, along with the review of systems.
- Physical Examination: general exam, cardiac, lung, EENT, neurological, musculoskeletal, abdominal, etc.
- Common Diagnostic Procedures: venipuncture and tests such as, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva, and pap smears.
- CLIA Approved Tests: pregnancy tests, urine analysis, etc.
- Dietary Advice and Therapeutic Nutrition: which may include lifestyle and nutritional counseling, diet plans, oral nutritional supplements (with vitamins, minerals, and amino acids), intra-muscular and intravenous vitamin, or supplemental injections.
- Botanical Medicines: substances may be given in the forms of teas, tinctures (which may contain alcohol), pills, suppositories, and creams.
- Homeopathic Remedies: highly diluted substances of naturally occurring plant, animal or other substances for healing.
- Prescription Medications: to be filled at a pharmacy.
- Physical Medicine: muscle release techniques, trigger point therapy.
- Chelation: heavy metal detoxification, oral and intravenous therapy.
- Over the counter medications.

I understand and I am informed that in the practice of Naturopathic Medicine there are risks and benefits with evaluation, diagnosis and treatment including, but not limited to the following:

- Potential Risks: allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition) to prescribed supplements, medications, and herbs; which may be severe such as anaphylaxis, cardiac arrest and death. Side effects between natural medications and pharmaceuticals, inconvenience of lifestyle changes, aggravation of present conditions, injuries such as pain, discomfort, discoloration, and pneumothorax from injections, venipuncture, and other procedures. Soft tissue or bony injury from physical manipulation. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.
- Potential Benefits: restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.
- Notice to Cancer Patients: Naturopathic doctors do not treat cancer. However, Naturopathic doctors treat the

immune system to be able to respond better to cancer. All healing is done by restoration of the immune system to full function.

- Notice to Women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy and/or fetus.

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 in recommending the treatments that the doctor feels at the time, based on the facts then known, are in my best interest. I have had the opportunity to ask questions and discuss with Dr. Anita M. Larrow, ND, and/or an allied health care provider to my satisfaction:

1. my suspected diagnosis or condition
2. the nature, purpose and potential benefit of the proposed care
3. the inherent risks, complications, potential hazards, or side effects of the treatment or procedure
4. the probability or likelihood of success
5. reasonable available alternatives to the proposed treatment / procedure
6. the possible consequences if treatment or advice is not followed and/or nothing is done.

With this knowledge I voluntarily consent to the above procedures, and practices realizing that no guarantees have been given to me by Anita M. Larrow, ND or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

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Patient Name Printed

Signature of Patient

Date

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Representative Name Printed

Signature of Representative

Date

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Relationship of Representative to Patient

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Lastly, and optionally, I agree, and consent to allow Anita M. Larrow, ND to put my email address in the subscription list for her 3rd party newsletter service, and that I may be informed of important general schedule, updates, and information regarding Dr. Larrow's practice through the 3rd party newsletter service that she is currently using. This agreement does not state that Dr. Larrow's newsletter is the only means of communicating the practice information mentioned as the information will also be posted on the company's website, blogs, mentioned in verbal phone contact, or other electronic communications with, or for me. This agreement does explicitly notify me, and any patient, that Dr. Larrow's newsletter is the preferred method of delivering important practice information, however she has not made this agreement to consent regarding her newsletter a requirement for conducting any business with her, or her practice.

(Initial here) \_\_\_\_\_ I allow Anita M. Larrow, ND to send important practice updates to me through a 3rd party newsletter service with my desired, and given email address if it is not already known to Anita M. Larrow, ND.

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(Optional desired Email Address to be used, if any)