DR. SCARLETT COOPER
naturopathic doctor

PATIENT INFORMATION AND CONSENT

Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's innate healing capacity. With that said, multiple approaches may be taken through the duration of your treatment including nutritional counseling, diet and lifestyle assessment and modifications, Traditional Chinese medicine and acupuncture, botanical medicine, homeopathy, hydrotherapy, and physical medicine.

Your initial visit to your Naturopathic Doctor will involve a thorough case history, physical examinations, and may involve referral for blood and urine tests.

Any therapy may cause complications, and individual response may be considerably different in each therapy. Some therapies may be used with caution in certain medical conditions or diseases such as heart, liver, and kidney diseases, diabetes, children, those currently taking medication or who are pregnant or breastfeeding. Thus, it is important that you inform your Naturopathic Doctor of any disease process from which you are suffering and any medications, over the counter drugs or supplements that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breastfeeding.

Some health risks associated with the use of naturopathic medicine include but are not limited to:

- Worsening of pre-existing symptoms;
- Allergic reactions to supplements and herbs;
- Bruising, pain, and bleeding from acupuncture needles and intramuscular injections;
- Fainting or puncturing of an organ from acupuncture needles

The staff is trained in emergency situations if the need arises.

Privacy of your personal information is very important and taken seriously. We collect, use and disclose your personal information responsibly, and take the following steps to respect your personal privacy:

- Only required information is collected;
- Your information is only shared with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of the naturopathic professions regulatory body.

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I, _____ (please print), consent to the procedures and treatment provided to me by Dr. Scarlett Cooper, of my own accord. I acknowledge and accept that there may be risks associated with these procedures and treatments and that they will be explained to me before any treatment is performed. I understand and acknowledge that at any time throughout treatment I may ask questions and that I am free to withdraw my consent and discontinue procedures or treatments at any time. I also understand and acknowledge that Dr. Scarlett Cooper is not able to anticipate, explain or expect all risks and complications and that no guarantees have been given to me regarding cure or improvement of my condition.

I hereby consent to the collection, use and/or disclosure of my personal information for purposes that relate to the provision of patient care and other related uses by Dr. Scarlett Cooper. I acknowledge that a record will be kept of the health services provided to me and that my personal information along with this record will be kept confidential. I further understand that no personal information will be released to others unless consented by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received from Dr. Scarlett Cooper, and that payments must be made at the time services are rendered and/or at the time products are purchased.

I understand that this office requires a minimum of twenty-four (24) hours notice to change or cancel any appointment. I understand if an appointment is missed or re-scheduled with insufficient notice the full appointment fee will be due.

I understand that claims for reimbursement from private insurance, ICBC, or other insurance companies are my own responsibility.

I have read and fully understand the clinic policies and I consent to be a patient at the clinic.

Signature: _____ Date: _____

If a minor, the parent or guardian: _____ _____
Print name Relationship

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