



## INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Tom Matteucci ND, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, \_\_\_\_\_, hereby request and consent to examination and treatment with Naturopathic Medicine by Dr. Tom Matteucci, ND, and/or other licensed doctors of naturopathic medicine serving as backup for him, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Tom Matteucci, ND, and/or with the allied health care provider providing backup:

- my suspected diagnosis(es) or condition(s)
- the nature, purpose, goals and potential benefits of the proposed care
- the inherent risks, complications, potential hazards or side effects of treatment or procedure
- the probability or likelihood of success
- reasonable available alternatives to the proposed treatment procedure
- potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical/herbal medicines, (prescribing of various therapeutic substances including plant, mineral, and animal materials). Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, topical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over-the-counter and prescription medications (including only those medications on the Formulary of California Naturopathic Doctors)

**Potential risks:** Including but not limited to pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; aggravation of pre-existing symptoms.

**Potential benefits:** Including but not limited to restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

**Notice to pregnant women:** All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the



induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

**Notice to individuals with bleeding disorders, pace makers, and/or cancer:** For your safety it is vital to alert your provider, Dr. Tom Matteucci, ND, of these conditions.

Please INITIAL the following:

\_\_\_\_\_ I understand that Dr. Tom Matteucci, ND, is not licensed to prescribe any controlled substances.

\_\_\_\_\_ I understand that Dr. Tom Matteucci, ND can only prescribe medications on the California Naturopathic Doctor's formulary and will only do so if he believes that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.

\_\_\_\_\_ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for many years.

\_\_\_\_\_ I understand that Dr. Tom Matteucci, ND is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Tom Matteucci, ND and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Matteucci explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

\* \* \*

I have read and understand my health information privacy rights as described herein.

\_\_\_\_\_  
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

\_\_\_\_\_  
Patient Signature (Parent/guardian signature if minor)

\_\_\_\_\_  
Date



## YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public’s health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

Please do not phone me at home. Use this alternate phone number: \_\_\_\_\_

Please do not phone me at work. Use this alternate phone number: \_\_\_\_\_

Please do not leave messages on my answering machine.

Please do not contact me by email.

Please send mail, including my bills, to this alternate address: \_\_\_\_\_

Other request (please describe): \_\_\_\_\_

\* \* \*

I have read and understand my health information privacy rights as described herein.

\_\_\_\_\_  
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

\_\_\_\_\_  
Patient Signature (Parent/guardian signature if minor)

\_\_\_\_\_  
Date



## PAYMENT AGREEMENT

Dear New Patient,

Welcome to Equinox Natural Medicine. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

\_\_\_\_\_ Payment for all services and medicinary items are due in full at the time of the visit. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a \$35.00 NSF fee. We do not bill insurance directly, but we will prepare a “super bill” which you can submit to your insurance company for reimbursement, if your insurance covers naturopathic medical visits.

\_\_\_\_\_ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your doctor will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Your doctor will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment.

\_\_\_\_\_ We request that you provide us with 24 hours advance notice of cancellations. Appointments missed or cancelled in less than 24 hours will incur a \$50 charge.

\* \* \*

I have read and understand the above-stated policies of Equinox Natural Medicine and will comply with them in all respects.

\_\_\_\_\_  
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

\_\_\_\_\_  
Patient Signature (Parent/guardian signature if minor)

\_\_\_\_\_  
Date