Big Sky Integrative Health, PLLC

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Informed Consent for Naturopathic Treatment

I,_____,hereby authorize the physicians of Big Sky Integrative Health to perform with my approval and consent the following procedures for my diagnosis and treatment:

Physical Exam: e.g. general, cardiac, lung, EENT, neurological, musculoskeletal.

Common Diagnostic Procedures: e.g. venipuncture, diagnostic imaging, laboratory.

Physical Medicine: e.g. muscle release techniques, osseous manipulation, therapeutic ultrasound, massage, trigger point therapy.

Dietary Advice and Therapeutic Nutrition: e.g. lifestyle and nutritional counseling, diet plans, nutritional supplements (with vitamins, minerals, and amino acids), botanical medicine (with teas, tinctures, capsules, tablets, and creams), intra-muscular and intravenous vitamin or mineral injections.

Homeopathic Medicine: e.g. using highly dilute quantities of naturally occurring plants, animals, or minerals for healing.

Immunizations: e.g. thimerosol-free vaccines, vaccine schedules on an individual basis.

Minor Surgery: e.g. biopsy, wounds, lacerations, cryotherapy, suturing.

Chelation: e.g. heavy metal detoxification, intravenous therapy.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risks: allergic reactions to prescribed supplements, medications, and herbs, side effects of natural medications, inconvenience of lifestyle changes, injuries from injections, venipuncture, or other procedures.

Potential Benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, and prevention of disease and its progression.

Notice to Women: all female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present risk to the pregnancy and fetus.

With this knowledge I voluntarily consent to the above procedures realizing that no guarantees have been given to me by Big Sky Integrative Health 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.

_____

Signature **Date**