

## INFORMED CONSENT FOR VIRTUAL NATUROPATHIC WELLNESS CONSULT

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, and promote health by assisting the body's own healing mechanisms. Naturopathic doctors are highly educated, primary health care providers who integrate standard medical diagnostics with a broad range of natural therapies, including Botanical Medicine, Nutraceuticals, Acupuncture, Medical Nutrition, Physical Medicine and Lifestyle counselling. When required, we will work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

### STATEMENT OF ACKNOWLEDGEMENT

I, \_\_\_\_\_, (please print name clearly) as a client of Dr. Andra Campitelli, ND, understand that the form of care is based on naturopathic principles and practices. I will inform my Naturopathic Doctor of all my health concerns, allergies, medications, supplements, and medical interventions, because safe care requires that I truthfully and completely disclose this information. \_\_\_\_\_ (initial)

I, the undersigned, do hereby acknowledge that Dr. Andra Campitelli is licenced to practice Naturopathic Medicine in Ontario, Canada. I understand that this is a virtual wellness consult, and therefore Dr. Campitelli can not perform a physical exam or provide medical diagnostics, due to the nature of this consult. I understand that Dr. Campitelli highly encourages that I continue to work with my primary care provider, and that this consult is not to replace the medical care of my general practitioner. \_\_\_\_\_ (initial)

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic procedure(s)/plan and have discussed to my satisfaction this and any requests for related information with Dr. Andra Campitelli and/or with her office or clinical assistant(s). \_\_\_\_\_ (initial)

I further acknowledge and confirm that I have been informed of, and understand the therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. \_\_\_\_\_ (initial)

I will inform my Naturopathic Doctor if I become pregnant and/or if I am breastfeeding. I understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side-effects. I am entitled to know the consequences of not accepting treatment and of alternative courses of action. I am always at liberty to seek or continue care from another qualified healthcare provider. I understand that although Naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to: allergic reactions to certain supplements and herbs \_\_\_\_\_ (initial)

#### I understand:

- The clinic does not guarantee treatment results
- That my naturopathic doctor will explain to me the exact nature of any treatment provided
- I am free to withdraw my voluntary informed consent and to discontinue treatment at any time
- That this is a phone consultation, and will provide a copy of my personal identification
- That physical exams and therefore diagnoses cannot be conducted via a telephone consultation

#### Fees

As the patient, you are responsible for the total charges incurred for each visit. Payment is due prior to each visit. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company and we will provide you with all of the information necessary to submit your claim for reimbursement. Your Naturopathic Doctor may prescribe supplements that can be purchased from our online dispensary, or elsewhere. Most insurance companies do not cover the cost of supplements, and these will be additional charges incurred. \_\_\_\_\_ (initial)

### PATIENT CONSENT

I have read and understand the above-stated statements, policies and information. As a result, I do hereby voluntarily grant my informed consent for the recommended diagnostic procedure(s) and/or therapeutic procedure(s)/plan specified above. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my voluntary informed consent and to discontinue participation in these procedures at any time.

Print Name Clearly \_\_\_\_\_

\_\_\_\_\_  
Patient or Lawful Representative Signature

\_\_\_\_\_  
Date Signed