



Consent to Treatment - Naturopathy

General Diagnostic procedures: Dr. Mackler may perform or recommend the following procedures as necessary to provide an assessment and design a treatment plan. These procedures may include but are not limited to; physical exam, pap smear, urine, blood, or saliva testing, diagnostic imaging, or psychological evaluation.

General Treatment Modalities: Naturopathic Medicine is a diverse system of medicine that may include one or more of the following therapies in your treatment plan:

- **Herbal Medicine:** Medicines made from plant, mineral or animal substances may be prescribed in tea, pill, tincture, powder or paste form. Homeopathic remedies may also be used.
- **Dietary/Nutritional Medicine:** The use of food, dietary plans or nutritional supplements may be prescribed for treatment.
- **Counseling:** Dietary, life, stress management, and exercise prescriptions may also be prescribed
- **Soft tissue manipulation:** such as massage, stretching and trigger point work
- **Thermal therapies:** Such as the use of infrared lamp or hydrotherapy alternation of hot and cold water.
- **Pharmaceutical Therapy:** in some cases the physician may prescribe a pharmaceutical medication with the scope of practice.

Potential Risks: Allergic reactions or side effects from herbs, supplements, or pharmaceutical medications are possible. Pain or discomfort from manual therapies, and an aggravation of pre-existing may also occur.

Potential Benefits: Relief of pain, symptoms of disease, assistance in injury recovery, prevention of disease, and slowing or halting disease progression. Restoration of the body's maximum functioning capacity.

Notice to Women: *All female patients must alert their doctor if they know or suspect that they are pregnant.* Some therapies used may pose a risk to pregnancy.

I understand that I may ask questions regarding my treatment before signing this form and I am free to withdraw my consent for treatment at any time. With this knowledge I voluntarily consent to the above procedures realizing that no guarantees are given for my recovery or improvement.

Patient/Guardians Name (Print)

Date

Patient/ Guardian Signature



Consent to Treatment - Acupuncture and Chinese Medicine

Acupuncture: This is a safe treatment involving the insertion of tiny sterile, disposable needles through the skin, which can produce a mild but temporary discomfort at the acupuncture site. It can occasionally cause slight bleeding, and will rarely leave a bruise. Other possible risks from acupuncture include dizziness and fainting. Extremely rare risks of acupuncture include nerve damage, organ puncture, and infection.

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of herbs, I understand that I should stop the herbs and that I am responsible for informing the LAc of my symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform the Licensed Acupuncturist of a suspected or confirmed pregnancy, or if I am a nursing mother.

Heat Treatment with a TDP Lamp: This is used to warm an area of the body. Every precaution is taken to prevent overwarming, but the rare possibility of mild burns exists.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Very rarely a slight burn or blister may appear due to the heat.

Electro-Acupuncture: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

By signing below, I show that:

- I have read, or had read to me, the information on this consent form,
- I understand the possible risks and complications involved. I have had the opportunity to discuss this consent form with my Licensed Acupuncturist. I understand that I can request more information at any time if desired.
- I consent to receiving treatment that involves the above procedures.
- I understand that I have the right to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.

Signature of Patient (or guardian)

Date

Printed name