

◆THE VMC NATURAL HEALTH CARE TEAM◆

VAUGHAN MEDICAL CENTRE

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**\*PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1<sup>ST</sup> APPOINTMENT**

**INFORMED CONSENT**  
**TO NATUROPATHIC/HOMEOPATHIC DIAGNOSTIC & TREATMENT PROCEDURES**

PATIENT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_

IN ORDER TO CLARIFY MY POSITION AS A HEALTH CARE PRACTITIONER AND MY MUTUAL RESPONSIBILITY IN HEALTH CARE, I, \_\_\_\_\_, HD/ND ASK FOR YOUR CO-OPERATION IN READING AND SIGNING THIS STATEMENT OF INFORMED CONSENT:

NATUROPATHIC & HOMEOPATHIC DOCTORS ASSESS THE WHOLE PERSON, TAKING INTO CONSIDERATION PHYSICAL, MENTAL, EMOTIONAL AND SPIRITUAL ASPECTS OF THE INDIVIDUAL. GENTLE, NON-INVASIVE METHODS ARE USED FOR ASSESSMENT OF BODILY FUNCTION AND NATURAL THERAPEUTICS ARE USED IN ORDER TO CORRECT IMBALANCES. THE CREDENTIALS OF YOUR

NATUROPATHIC/HOMEOPATHIC DOCTOR IS ONE WITH A MINIMUM OF 8 YEARS UNIVERSITY EQUIVALENT INCLUDING 4 YEARS UNDERGRADUATE AND 4 YEARS POST GRADUATE (WITH CLINICAL COMPONENT) AT AN ACCREDITED NATUROPATHIC/HOMEOPATHIC MEDICAL COLLEGE IN TORONTO,

NATUROPATHIC/HOMEOPATHIC DOCTORS ARE NOT MEDICAL DOCTORS (M.D.'S). THEREFORE IF STANDARD MEDICAL TREATMENT (DRUGS, SURGERY, ETC.) IS NECESSARY, IT MUST BE OBTAINED FROM A MEDICAL DOCTOR.

YOUR SIGNATURE IS REQUIRED BEFORE ANY TREATMENT IS RENDERED. YOUR SIGNATURE ACKNOWLEDGES THE FOLLOWING:

1. YOU HAVE READ THE FOREGOING INFORMATION AND THAT YOU UNDERSTAND THAT YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR OWN HEALTH.
2. AS A NATUROPATHIC/HOMEOPATHIC DOCTOR I WILL TAKE A THOROUGH PERSONAL AND FAMILY HISTORY, PERFORM A PHYSICAL EXAM AND REQUEST AND REVIEW LABORATORY TESTING. AFTER COLLECTING THE NECESSARY INFORMATION; DIAGNOSIS, TREATMENT AND/OR REFERRAL TO OTHER HEALTH CARE PROFESSIONALS ARE MADE BASED UPON THE ASSESSMENT OF CONDITIONS REVEALED.
3. AS A NATUROPATHIC/HOMEOPATHIC DOCTOR, I FACILITATE YOUR HEALING PROCESS IN A MANNER THAT IS COMPATIBLE WITH YOUR BELIEFS AND LEVEL OF COMMITMENT.
4. IT IS VERY IMPORTANT THAT YOU INFORM ME, OF ANY DISEASE PROCESS THAT YOU ARE SUFFERING FROM AND ANY MEDICATIONS/OVER THE COUNTER DRUGS THAT YOU ARE CURRENTLY TAKING. PLEASE ADVISE ME IMMEDIATELY

IF YOU ARE PREGNANT, SUSPECT YOU ARE PREGNANT OR IF YOU ARE BREAST-FEEDING.

5. WHILE CHANGES IN DIETARY HABITS ARE NOT A PREREQUISITE FOR TREATMENT, FAILURE TO FOLLOW THE RECOMMENDED NUTRITIONAL AND EXERCISE PROGRAMS COULD UNDERMINE THE EXPECTED RESULTS.
6. YOU UNDERSTAND THAT THAT IT TAKES TIME TO FEEL BETTER WHEN USING NATURAL MEDICINE. SOME PATIENTS USING NATURAL MEDICINE NOTICE A DIFFERENCE AFTER 4 VISITS WHILE OTHERS SEE CHANGES SOONER. YOU ACCEPT THAT POSITIVE CHANGES WILL OCCUR MORE RAPIDLY WITH INCREASED COMPLIANCE.
7. YOU ARE ACCEPTING OR REJECTING THIS NATURAL MEDICAL CARE OF YOUR OWN FREE WILL AND CHOICE. YOU ARE FREE TO WITHDRAW YOUR CONSENT AND TO DISCONTINUE TREATMENT AT ANY TIME.
8. IF YOU HAVE ANY QUESTIONS REGARDING YOUR TREATMENT PROGRAM, YOU WILL CLARIFY THESE ISSUES WITH YOUR NATUROPATHIC/HOMEOPATHIC DOCTOR.
9. YOU ARE NOT AN AGENT OF ANY PRIVATE, LOCAL, COUNTY, PROVINCIAL OR FEDERAL AGENCY ATTEMPTING TO GATHER INFORMATION WITHOUT STATING YOUR INTENTION TO DO SO.
10. THERE ARE SOME SLIGHT HEALTH RISKS ASSOCIATED WITH TREATMENT BY NATURAL MEDICINE.

THESE INCLUDE BUT ARE NOT LIMITED TO:

- HOMEOPATHIC REMEDIES MAY OCCASIONALLY RESULT IN THE AGGRAVATION OF PRE-EXISTING SYMPTOMS. WHEN THIS OCCURS THE DURATION IS USUALLY SHORT.
- SOME PATIENTS EXPERIENCE ALLERGIC REACTIONS TO CERTAIN SUPPLEMENTS AND HERBS. PLEASE ADVISE ME OF ANY ALLERGIES YOU MAY HAVE
- PAIN, BRUISING OR INJURY FROM ACUPUNCTURE
- MUSCLE STRAINS AND SPRAINS, DISC INJURIES FROM SPINAL MANIPULATION
- THERE IS A VERY SMALL POTENTIAL RISK FOR STROKE IN NECK MANIPULATION. PATIENTS ARE THOROUGHLY SCREENED PRIOR TO NECK MANIPULATION.
- MY STAFF AND I ARE TRAINED TO HANDLE EMERGENCIES SHOULD THE NEED ARISE.
- *72 HOURS NOTICE IS REQUIRED FOR CANCELLATION OF APPOINTMENTS. FAILURE TO DO SO WILL RESULT IN THE PATIENT BEING CHARGED FOR THE FULL AMOUNT OF THE VISIT.*

I \_\_\_\_\_ (PLEASE PRINT),

HAVE READ, UNDERSTOOD AND ACKNOWLEDGE THE ABOVE STATEMENTS.

MASTERCARD/VISA # \_\_\_\_\_ EXPIRY DATE \_\_\_\_\_

PATIENT OR LAWFUL REPRESENTATIVE SIGNATURE \_\_\_\_\_

DATE SIGNED \_\_\_\_\_ EMAIL \_\_\_\_\_