CONSENT FOR TREATMENT

General Information: Teresa Richter, ND is a clinic that integrates a number of medical treatment modalities. Your medical history, treatment plan and progress is discussed (without identifying information) among other clinicians for treatment purposes at the clinic. Due to the diversity of modalities offered at TRND, your treatment may include any or all of the following general modalities: Chiropractic care, Naturopathic Medicine, Physical Medicine, Homeopathy, Acupuncture, Psychological Counseling and Nutritional Counseling. All medical practitioner faculty are licensed in the State of Washington having completed graduate level training and national board certification.

Methods, Procedures and Therapeutic Approaches: Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

General Diagnostic Procedures: including but not limited to venipuncture, pap smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Herbs/Natural Medicines: prescribing therapeutic substances, which include plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, plasters, washes; suppositories or other forms. Homeopathic remedies, often highly diluted quantities of naturally occurring substances, may also be used.

Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.

Soft Tissue and Osseous Manipulation: use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy.

Electromagnetic and Thermal Therapies: includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy and infrared and ultraviolet therapies or moxa (warming or indirect burning of an acupuncture point and hydrotherapies.)

Injection Therapy: use of therapeutic intramuscular injections for the purpose of vitamin therapy, pain relief including neural therapy and prolotherapy.

Intravenous Therapy: use of inravenous substances for the purpose of vitamin therapy; not only to repleat a deficiency, but also as it pertains to treatment of certain conditions.

Potential Risks: While not common, can potentially occur from any therapy. Some examples include but are not limited to: pain, discomfort, blistering, discolorations, infection, or burns from topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms, infections, bruising, and pain at injection site from injections.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of a disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by TRND or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

_____ (Patient Signature) **_____ (Date)**

_____ Patient's Name (PRINT)

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