LAKE NATURAL MEDICINE

Dr. Gregory L. McDonald, ND, LAc
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Informed Consent and Request

I authorize Dr. Gregory McDonald, ND, LAc to perform these modalities during the course of my treatment. It is my right to request that Dr. McDonald explains treatments to my satisfaction.

Please INITIAL treatments you authorize:

____ General naturopathic medicine
____ Structural manipulation (DNFT, trigger point therapy, etc.)
____ Micro-current (hand-held electro stimulation device)
____ Acupuncture (body acupuncture with needles inserted into the skin and removed after treatment)
____ Auricular medicine (ear acupuncture with tiny needles left in the earlobe until they come out)

Consent for Naturopathic Medical Care - I understand that my treatment may include:

- Physical exam (including general and musculoskeletal) and common diagnostic procedures
- Soft tissue and spinal or extremities manipulation, DNFT adjustments (Directional Non-Force Technique)
- Botanical, homeopathic and herbal medicines (including plant, mineral, and animal materials) in the form of teas, pills, powders and tinctures (which may contain alcohol)
- Nutritional therapy

Consent for Acupuncture and/or Auricular Medicine - I understand that my treatment may include:

- Insertion of fine, acupuncture needles into the skin at various depths
- Insertion of tiny needles into the ear lobe area, which may remain in place for a few days or weeks
- Use of a heat lamp to augment effectiveness of the needles

Please *INITIAL* the following:

_____ I understand that if I experience any unusual discomfort or pain following treatment, or any adverse reaction to remedies given by Dr. McDonald, I should call the office immediately.

_____ I understand that Structural Manipulation adjustments may be given in the diaphragm or pelvic area while I am lying face-up on the table, or to the tailbone and buttocks area while I am lying face down on the table.

_____ I understand that adverse side effects from Chinese herbal, homeopathic and other remedies may include, but are not limited to, changes in bowels, gas, allergic reactions, or aggravation of symptoms.

_____I do not expect Dr. McDonald to be able to anticipate and explain all of the risks and complications. I acknowledge that no guarantee of services has been made to me concerning the results from any treatment provided.

By signing below, I request and give my consent to receive treatment.

_____
Printed Name of Patient or Guardian (if applicable)

_____ _____
Signature of Patient or Guardian **DATE**