Informed Consent to Naturopathic Consultation

I, ______________________________________, consent to receive naturopathic consultation services from ***Rooted Remedies.***

I understand that the consulting services provided are not meant to be used in place of allopathic medical care. I agree that it is in my best interest, and my sole responsibility to retain an allopathic primary care provider (D.O.M., M.D., or D.O.) to assess my health care needs.

I understand that the services provided by ***Rooted Remedies*** may include lifestyle changes, dietary and vitamin/nutrient recommendations, herbal and/or homeopathic remedies, flower essences, hydrotherapy, physiotherapy, and manual techniques. These treatments are considered safe but may have side effects. The risks and the benefits of each recommendation will be discussed prior to implementation.

I agree to inform my practitioner immediately if:

* I am pregnant
* If I have any changes to my prescriptive medications
* If I experience any negative side effects

My signature below confirms that I have read, or have had read to me, this consent to naturopathic consultation; understand the nature of and purpose of the services, understand the risks and benefits of specifically recommended modalities, and have had an opportunity to ask questions.

Print name

____

Signature Date

____