Dr. Elaina Mansour, ND Inc

Naturopathic Consent Form

Please read the following carefully and let us know if you have any questions.

Clinic Introduction

We would like to take this opportunity to sincerely welcome you to Glow Acupuncture and Wellness Centre. As part of your visit, assessment and treatment with the naturopathic doctor (ND), the principles of naturopathic will be utilized in order to support the body's natural healing abilities, treat the root cause of disease and improve the overall health of patients through natural therapies.

As part of your assessment, a thorough case history and physical examination will be conducted. Examination may also include traditional Chinese medicine diagnosis and work-up. Specific blood, urine or other laboratory testing may also be conducted as part of the assessment.
Therapeutic procedures/treatment utilized in naturopathic medicine may include botanical medicine, acupuncture, homeopathy, clinical nutrition, lifestyle counseling, spinal adjustment, and intravenous nutritional therapy.

Clinic Policies

Patient Confidentiality

Patient confidentiality is of the utmost importance to us. The naturopathic doctor is required to maintain patient confidentiality, in accordance to the bylaws of the College of Naturopathic Physicians of British Columbia (CNPBC). The personal information collected is for the sole purposes of providing health care and for administrative purposes.
The doctor may correspond with you via email in regards to providing general health information, answering questions, etc. As with any correspondence with the doctor, patient confidentiality is of the utmost importance.
Please indicate if you consent to e-mail communication: Yes □ No □

Payment and Cancellation Policy

The patient is responsible for payment and payment is due when services rendered.
Please provide us with at least 24 hours notice of an appointment cancellation or re-scheduling, by calling our clinic at 778-786-2517 or email dr.mansournd@gmail.com .

Informed Consent

As a diagnosis is made, treatment options will be provided to patients. It is the patient's choice to agree to or deny treatment. Before consent is obtained, the naturopathic doctor will ensure you are informed of what the treatment entails, benefits, alternatives, risks, costs and adverse effects of the proposed treatment. This will also be done for alternative treatments, along with the risks of not treating the diagnosed condition. There is no guarantee for any treatment results or outcomes. The naturopathic doctor will either have you sign a consent form for the chosen treatment, if needed, or verbally agree to the treatment. Scheduling an appointment for specific treatment is considered consent for that treatment. You have the right to refuse or withdraw consent to any treatment at any time.

Complications may arise with treatment. Treatments used in naturopathic medicine are very gentle, safe and meant to improve your health, but with any treatment, there may be complications. Chances of complications are minimal. These include, but are not limited to: aggravations of pre-existing symptoms, allergic reactions to botanical medicine or supplements, soreness, soft tissue injury, bruising or injury from venipuncture or acupuncture, fainting, muscle strains from spinal manipulation and stroke, as well. Before any spinal manipulation is performed, patients are thoroughly screened by the doctor in order to determine if it is a correct and appropriate treatment for them.

Statement of Acknowledgement

I have read the above information and understand that the medical care that will be provided to me is based on the principles of naturopathic medicine. I recognize that though therapies utilized in naturopathic medicine are gentle and safe, complications, though uncommon may arise. The information I have provided about my health is complete and inclusive of all health concerns, including pregnancy, and prescription and non-prescription medications.

I, _____, have read, understand, and agree to the above
clinic policies and informed consent.

Signature of patient (or guardian*):

_____

Full Name (please print):

_____

Date:

_____

*If under the age of 19, you will need a parent or guardian to sign the consent form.