Katherine Reinholtz, N.D.
NATUROPATHIC MEDICINE

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Consent for Treatment
Naturopathic Medicine

I hereby request and consent to the performance of naturopathic treatments and other procedures within the scope of the practice of naturopathic medicine on my (or on the patient named below, for I am legally responsible) by my naturopathic doctor Katherine Reinholtz, ND.

I understand that in the state of New York Dr. Katherine Reinholtz, ND is not licensed to diagnose and treat disease. The services rendered during visits with Dr. Reinholtz are not a replacement for routine medical care or laboratory work.

I understand that methods of treatment may include, but are not limited to: homeopathy, botanical medicine, nutritional and dietary counseling, flower essence therapy, and nutritional supplementation. I understand that all treatments should be consumed according to the instructions provided orally and in writing. I will immediately notify my doctor of any unanticipated or unpleasant effects associated with the treatment.

I have been informed that naturopathic medicine generally provides safe methods of treatment, yet the potential for side effects exists. The herbs, remedies and nutritional supplements that have been recommended are traditionally considered safe, although some may be toxic in large doses.

I understand that some herbs and supplements may be inappropriate during pregnancy or breastfeeding. I will notify the naturopathic doctor who is caring for me if I am or become pregnant or am currently breastfeeding.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I have fully read and understand the above agreements.

_____ _____

Signature (Patient 18 years or older) Date

_____ _____

Parent, Guardian, Responsible party Date