Access to Health Chiropractic Center (860) 889-1475 p
57 Lafayette St. Norwich, CT 06360 (860) 889-2850 f

Informed Consent for Treatment

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 whom I am legally responsible) by Kathleen Cannon, ND and/or other licensed naturopathic doctors who or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Cannon, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: homeopathy, botanical medicine, nutritional counseling, lifestyle counseling, hydrotherapy, genetic evaluation and analysis, energy medicine, naturopathic manipulation and so on. I understand that the herbs, remedies and supplements should be consumed according to the instructions provided orally and in writing. I will immediately notify Dr. Cannon of any unanticipated or unpleasant effects associated with the herbs, remedies or supplements.

I have been informed that naturopathic medicine is a generally safe method of treatment, but that it may have some side effects, such as a healing crisis which could cause fatigue, nausea, muscle soreness, headache, etc. 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 Dr. Cannon if I am or become pregnant or am currently breastfeeding.

I do not expect all possible risks and complications of treatment to be anticipated or explained, and I wish to rely on Dr. Cannon to exercise judgment during the course of treatment as to which treatment, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of naturopathic medicine and other procedures, and have had an opportunity to ask questions. 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.

Accordingly, I sign this Informed Consent, to express that it is my own decision without undue persuasion to see Dr. Cannon for naturopathic treatment. I hold no party responsible for my own actions. I hereby release Dr. Cannon and The Cannon Clinic, LLC from liability for any results that may occur to me thereafter.

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In an effort to best serve clients, please give at least 24 hours notice when canceling an appointment. In the event that an appointment is cancelled with less than 24 hours notice, a fee will be charged. Thank you for your cooperation.

I understand that I am responsible for providing my insurance information or payment in full, as relevant. The appointment fees are available through the office and also upon request.

In addition, I acknowledgement receipt of The Cannon Clinic's Privacy Practices and understand the privacy practices terms may change at any time and are available in our office and upon request.

Patient Name: _____

Signature: _____ Date: _____
(Or Patient Representative - indicate relationship if signing for patient)