Maggie Thibodeau, ND

Cary Holistic Health, LLC

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Informed Consent of Naturopathic Medical Care

Welcome to Cary Holistic Health. This clinic utilizes the principles of naturopathic medicine, helping identify obstacles to healing & promoting the body's own ability to achieve its natural state of health.

Naturopathic Medicine

Offers a customized approach to health care. Naturopathic Doctors assess the whole person and recommendations are tailored to suit individual needs. Gentle, non-invasive techniques are generally used to stimulate the body's inherent healing capacity. Therapies used by a Naturopathic Doctor may include: Clinical nutrition, Botanical medicine, Homeopathic medicine, Lifestyle counseling, Hydrotherapy and Physical medicine. Under current North Carolina law, Naturopathic medicine is not deemed the practice of medicine and is not regulated by state law. However, naturopathic medicine is considered a complement to traditional allopathic medicine.

Clinical Nutrition

Examines the relationship between diet and health. Special diets may be recommended. Other recommendations may include nutritional supplements such as vitamins, minerals, enzymes and other nutraceuticals.

Botanical Medicine (herbal medicine)

Uses plant substances for their healing effects and nutritional value. Plant substances may be prescribed as teas, tinctures, capsules or decoctions (strong teas) to be taken internally or used externally as a wash, poultice, or salve.

Homeopathic Medicine

Is based on the principle of "like cures like" and uses minute amounts of natural substances to stimulate the self-healing abilities of the body.

Lifestyle Counseling

Involves identifying risk factors and helping patients to make informed choices to reach and maintain optimal health.

Hydrotherapy

Refers to the use of water applications to the body.

Physical Medicine

Includes the use of hands-on techniques to manipulate the spine, joints and soft tissues. Therapeutic use of light, heat and cold, massage and ultrasound may also be incorporated into treatment.

Your Naturopathic Doctor will take a thorough case history. Assessment of each patient's physical, mental, emotional, spiritual and environmental well-being is required to facilitate this work. A basic/ complaint-oriented physical exam and specific urine and/or blood laboratory tests and/or reports may be used as part of the work-up.

Declaration and Consent to Treatment

I understand that Dr. Maggie Thibodeau is not a medical Doctor. If a medical diagnosis or treatment is required, it must be obtained from a licensed medical doctor. _____ *(Initials)*

I understand that North Carolina does not currently regulate Naturopathic Medicine, but that Dr. Thibodeau holds current licenses in the state of Vermont.
_____ *(Initials)*

Naturopathic Physicians are unable to fill the role of a primary care provider in North Carolina. Dr. Thibodeau asks that you maintain a relationship with a licensed primary care physician and can provide a list of physician referrals if needed. _____ *(Initials)*

I understand that the form of medical care provided at this clinic is based on Naturopathic Medicine and other supportive principles and practices. I recognize that even the gentlest therapies may cause complications in certain physiological conditions such as pregnancy, lactation, very young children, very elderly patients, those on multiple medications, or those with specific diseases such as heart, liver, kidney or diabetes. I therefore confirm that I will inform, and will continue to inform, my Naturopathic Doctor fully of my medical history, family history, medications and/or supplements I am currently taking (prescription and over-the-counter), or was previously taking. If female, I will advise my Naturopathic Doctor immediately if I am pregnant, suspect I am pregnant, am trying to become pregnant, or if I am breast-feeding, and will continue to do so. _____ *(Initials)*

I understand that health risks associated with naturopathic medical treatment include, but are not limited to:

- Aggravation of pre-existing symptoms.
- Allergic reactions to supplements or herbs.

_____ (Initials)

I understand that a health record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research and treatment purposes, but that my identity will be protected and kept confidential. _____ *(Initials)*

I understand that my Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that, as with any type of treatment, results can not be guaranteed. I do not expect my Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the assessment and therapeutic procedures mentioned above, except for (please list any exceptions):
_____ *(Initials)*

I acknowledge that I have been informed and I understand that:

- Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving, or may in the future receive, from a licensed health care provider.
- I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in North Carolina.
- No employee or other practitioner under the Cary Holistic Health direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider.
- The treatment and therapies rendered or recommended by Cary Holistic Health may be different than those usually offered by a medical doctor or other licensed health care provider. _____ (Initials)

_____

I have read and understand the above stated policies and information. I have received a full and complete explanation of the treatment and services that I may receive at the Cary Holistic Health. I hereby authorize and consent to treatment. I intend this consent form to cover the entire course of treatment I receive at the Cary Holistic Health. I also confirm that I may revoke this authorization for treatment at any time but will be financially liable for all treatment rendered. I also represent that I am not an agent of any private, local, county, state or federal agency attempting to gather information without so stating.

Patient Name (Please print.):

_____
First Middle Last

Date of Consent: _____
Month Day Year

Signature of Patient (or Parent or Legal Guardian):

_____

Financial Policy Payment for Services

As the patient, you are responsible for the total charges incurred for each visit. Payment by cash, check or Visa/Mastercard is accepted. Returned checks will be subject to a $25 return fee. If your insurance plan covers Naturopathic Medicine, we will provide you with receipts to submit for reimbursement.

Fees are to be paid at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees, as well as other applicable fees.

Telephone support is to assist in clarifying recommendations made during an office visit. Telephone conversations that cover new material or require an extended amount of time will be billed at the same rate as an office visit.

Naturopathic recommendations may include certain herbal, homeopathic, vitamin or mineral supplements. Please note that you are free to choose where you purchase the recommended products. Cary Holistic Health offers an herbal dispensary and carries a limited selection of professional quality products. Know that your practitioner has spent time researching and identifying well-made supplement brands and that these can be purchased from the in-house dispensary. All associated costs will be made aware to the client upon recommendation of specific health products. Payment for supplements is your sole responsibility.

Cancellation policy

Please give at least 24 hours notice if you need to cancel or reschedule an appointment. Missed appointments will be billed in full. We are willing to make exceptions for an emergency or unforeseeable circumstance.

I have read, understand and agree to the above financial and cancellation policies.

Patient Name (Please print.):

_____

First Middle Last

Date of Consent: _____

Month Day Year

Signature of Patient (or Parent or Legal Guardian):

_____