INFORMED CONSENT FOR TREATMENT

M. SAMM PRYCE, ND AND BALANCED INTEGRATION, LLC

I, as a patient, have the right to be informed about my condition and recommended care. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care having had the opportunity to discuss the potential benefits, risks, and hazards involved.

I, _____, hereby request and consent (or for the patient named the below for whom I am legally responsible) to examination and treatment with naturopathic medicine by M. Samm Pryce, N.D. and/or other naturopathic physicians or students training at the office. I can request students and preceptors not be included in my evaluation.

I understand that I have the right to ask questions and discuss to my satisfaction with M. Samm Pryce, N.D.:

1. My suspected diagnosis or condition
2. The nature, purpose and potential benefits of the proposed care
3. The inherent risks, complication, potential hazards, or side effects of treatment or procedure
4. The probability or likelihood of success
5. Reasonable available alternatives to the proposed treatment or procedure
6. The possible consequences if treatment or advice is not followed and/or nothing is done.

I understand that naturopathic evaluation and treatment may include, but is not limited to:
Physical exam: e.g. general, musculoskeletal, cardiovascular, gynecological, abdominal, respiratory.
Common diagnostic procedures: laboratory evaluation of blood, urine, stool and saliva
Dietary advice and therapeutic nutrition: use of foods, diet plans, nutritional supplementation.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, powders, plasters, washes or suppositories.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Psychological counseling: mind-body spirit techniques and basic counseling interactions including but not limited to guided imagery, visualization, relaxation response, breathing exercises
Hydrotherapies: use of hot and cold water e.g., hydrocolator, contrast treatments, wet sheet wrap.
Soft tissue manipulation: massage, neuro-muscular technique, muscle energy stretching.
I recognize the potential risks and benefits of these procedures as described below:
Potential risks: allergic reactions to prescribed herbs and supplements and prescription medications; side effects of natural medications, inconvenience of lifestyle changes, injury from procedures or soft tissue manipulation; an aggravation of pre-existing symptoms.
Potential benefits: restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.
Notice of individuals with bleeding disorders, pace makers and cancer. For your safety, it is important to alert the provider of these conditions.

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Please initial on each line below:

_____ I understand Dr. Pryce is not licensed by the state of Michigan to practice naturopathic medicine. There is not currently a naturopathic license available in Michigan. The use of the word doctor reflects Pryce's level of training (Doctorate of Naturopathic Medicine), and the practice of naturopathic medicine is not specifically regulated by the state of MI. Pryce is a Connecticut licensed naturopathic physician, in order to indicate that the training requirements and continuing education requirements for naturopathic practice are upheld.

_____ I understand the U.S. Food and Drug Administration has not evaluated or approved nutritional, herbal and homeopathic supplements, and therefore should not be taken as such. However, they have been widely used in Europe, China and the U.S.A for years.

_____ I understand that (as with drugs) nutritional supplements, herbal and homeopathic remedies may exhibit some side effects in certain sensitive individuals, may interact with certain allopathic medications or lab tests, or show symptoms due to certain pre-existing disease conditions.

_____ **I understand that it is not being recommended to me to discontinue any other treatment or care being provided by any other health care professional.** I understand Dr. Pryce does not function as a primary care physician, and that she offers her services in addition to other services I receive. I understand she does not replace the services of my primary care physician. The consultee(s) understand(s) that Dr. Pryce cannot manage the overall care of the person for whom the consultation is occurring, and it is my responsibility to seek conventional medical care for my health concerns.

_____ I understand that if I refuse to seek conventional medical care for my condition, this refusal of care is directly against the advice of Dr. Pryce.

_____ I understand that Dr. Pryce is not licensed to prescribe any controlled substances.

_____ I understand that Dr. Pryce will only prescribe medications (natural or over the counter) if she thinks it is in the best interest of the patient. Appropriate referrals will be provided to manage the patient's prescriptive medication needs.

_____ I understand that Dr. Pryce is not a psychologist or psychiatrist. Counseling services are for the improved lifestyle strategies and wellness.

_____ I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. Exceptions to confidentiality are: danger to yourself; danger to another; or child abuse. The privileged nature of our communication ceases under these circumstances. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential.

_____ I hereby give my consent for Dr Pryce and Balanced Integration, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices (NPP) provided by Dr Pryce and Balanced Integration, LLC describes such uses and disclosures more completely).

_____ I have had the right to review and to take a copy home with me, the Notice of Privacy Practices. Dr Pryce and Balanced Integration, LLC reserves the right to revise the (NPP) at any time. A revised (NPP) may be obtained by forwarding a written request to our office: 2190 S. State St. Ann Arbor, MI 48104

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Please initial on each line below:

With this consent, Dr Pryce or an employee of Balanced Integration, LLC may call, email or mail to my home address, home phone, cell phone, and any email address or other alternative location and leave a message/text in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results, among others.

_____ _____
Signature of Patient of Legal Guardian Date

_____
Print Patient's Name

_____
Print Name of Legal Guardian, if applicable