Donna Kachinskas, PhD,ND

INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Donna Kachinskas,PhD, ND .to perform or refer for the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, laboratory, X-ray.
Minor office procedures: e.g., dressing a wound, ear cleansing.
Medicinal use of nutrition: e.g., therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, 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.
Hydrotherapy: e.g., constitutional hydrotherapy treatments with electrostimulation, contrast baths.
Manual Therapy: e.g., musculoskeletal physical therapy, massage, craniosacral techniques
Pharmaceutical medicine: e.g., prescription of pharmaceutical drugs as determined by Washington State naturopathic scope of practice.
Lifestyle counseling and hygiene: e.g., diet therapy, biofeedback training, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
Psychological counseling
Contraception

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

Potential benefits: restoration of health and the body's maximal functional 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: If I am pregnant or suspect pregnancy, I will alert the doctor, as some of the therapies used could present a risk to the pregnancy.

Notice to cancer patients: I am aware that in the State of Washington I must have a medical oncologist to provide oncology treatment. I authorize the physicians of Red Cedar Wellness Center to review my records and discuss my health and treatment with other care providers. I authorize the release of medical information necessary to file a claim with my insurance company.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Red Cedar Wellness Center or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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. 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 that 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 understand that any questions I have will be answered by my physician to the best of her ability.

My signature confirms that I am informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that I may request in writing that RCWC restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that RCWC is not required to agree to my requested restrictions, but if agreeable then is bound to abide by such restrictions.

_____ _____
Signature of Patient or Guardian Date