



Informed Consent for Naturopathic & Chiropractic Treatments

This document is intended to inform you about naturopathic and chiropractic care so you may make an informed decision about your treatment. Please read it carefully and ask any questions you may have before signing.

General Consent to Care. I voluntarily consent to evaluation and treatment provided by the licensed/registered providers at Freedom Health Center of Minnesota. I understand that I have the right to ask questions, seek second opinions, and decline or discontinue care at any time. I understand that it is my responsibility to ask questions if I do not understand any aspects of my care.

No Guarantee of Results. I acknowledge that I have been advised that no guarantee or assurance has been made regarding the results of treatment.

Informed Consent for Naturopathic Care. Naturopathic medicine is a system of primary health care that emphasizes prevention, the body's inherent ability to heal, and the use of natural and least invasive therapies when appropriate. Though naturopathic doctors are trained in primary care, under Minnesota statutes, naturopathic doctors cannot be referred to as primary care physicians. It is my responsibility to maintain an ongoing relationship with a defined primary care physician. Naturopathic treatment plans are individualized and may include, but are not limited to:

Clinical nutrition and dietary counseling	Physical medicine modalities
Lifestyle and behavioral counseling	Functional and specialty laboratory tests
Botanical (herbal) medicine	Health education and preventive care
Nutritional supplementation	

Potential Benefits. Naturopathic care may help support overall health, address underlying contributors to illness, and improve quality of life. Benefits vary by individual and condition.

Potential Risks and Side Effects. As with any medical intervention, naturopathic treatments carry potential risks, which may include but are not limited to:

- Allergic reactions or sensitivities to supplements or botanicals
- Gastrointestinal upset or changes in bowel habits
- Temporary worsening of symptoms
- Interactions with prescription medications

I understand it is my responsibility to inform my provider of all current medications, supplements, and medical conditions.

Alternatives. Alternatives include, but are not limited to: conventional medical care, pharmaceutical treatment, and no treatment.

Scope and Limitations. I understand that naturopathic care is not a substitute for emergency medical treatment. I will seek immediate medical attention or call 911 for urgent or life-threatening conditions.

Informed Consent for Chiropractic Care. Chiropractic care focuses on the diagnosis and treatment of neuromusculoskeletal conditions, primarily through spinal and joint adjustments and related therapies. Treatment may include:

- Spinal and extremity adjustments or manipulation
- Manual therapies
- Soft tissue techniques
- Therapeutic exercise and rehabilitation
- Physical modalities

Potential Benefits. Potential benefits may include improved joint mobility, decreased pain, improved function, and enhanced overall well-being.

Potential Risks and Side Effects. Chiropractic treatment, including spinal manipulation, carries potential risks, which may include:

- Temporary soreness, stiffness, or discomfort
- Muscle or ligament strain
- Disc injury or aggravation of existing disc conditions
- Rare but serious complications such as fracture, neurological injury, or vascular events

I understand that these risks are uncommon but possible.

Alternatives. Alternatives to chiropractic care may include: medical care, physical therapy, medication, Surgery, and no treatment.

Imaging and Referrals. I understand that my chiropractor may recommend imaging studies or referral to another healthcare provider if clinically indicated.

Consent and Acknowledgement. I certify that I have read and understand this informed consent. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I voluntarily consent to naturopathic and/or chiropractic evaluation and treatment.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Provider/Witness Signature: _____ Date: _____

If the patient is a minor:

Parent/Guardian Name (print): _____ Relationship to patient: _____

Parent/Guardian Signature: _____ Date: _____