INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Sharum Sharif, ND to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Physical exam: e.g. General, musculoskeletal, cardiovascular, gynecological, abdominal, respiratory
Botanical medicine: Botanical substances prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, 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
Medicinal use of nutrition: Therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections
Lifestyle counseling and hygiene: Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities

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 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: 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.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the doctor 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. 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 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 full disclosure of information has been made to me and all my questions have been answered to my full satisfaction.

Date: _____ Signature of Patient: _____

Original to: Chart
Copy to: Patient (if requested)

_____
Signature of Patient Representative or Guardian