

D'VINE LIVING

Dr. Sharon Edwards HD(Rhom), DNM, RNCP

HOMEOPATHIC DOCTOR
DOCTOR OF NATURAL MEDICINE
REGISTERED NUTRITIONAL CONSULTANT

325 FAIRVIEW DRIVE, UNIT #1 BRANTFORD , ON N3R 2X3 ~ 519.750.0440.

INFORMED CONSENT TO HOMEOPATHIC DIAGNOSTIC & TREATMENT PROCEDURES

PATIENT NAME _____
ADDRESS _____
PHONE# _____
EMAIL _____
DATE OF BIRTH _____

In order to clarify my position as a Health Care Practitioner and my mutual responsibility in health care, I, Sharon Edwards, HD(Rhom), DNM, RNCP ask for your co-operation in reading and signing this statement of informed consent:

Homeopathic and Doctors of Natural Medicine assesses the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive methods are used for assessment of bodily function and natural therapeutics are used in order to correct imbalances. Homeopathic Doctors are not Medical Doctors (M.D.'s). Therefore if standard medical treatment (drugs, surgery, etc) is necessary, it must be obtained from a Medical Doctor.

Your signature is required before any treatment is rendered. Your signature acknowledges the following:

1. You have read the foregoing information and that you understand that you are ultimately responsible for your own health.
2. As a Doctor of Natural Medicine and a Homeopathic Doctor, I will take a thorough personal and family history, perform a physical exam and request and review laboratory testing. After collection of the necessary information, diagnosis, treatment and/or referral to other health care professionals are based upon the assessment of conditions revealed.
3. As a Doctor of Natural Medicine and a Homeopathic Doctor, I facilitate your healing process in a manner that is compatible with your beliefs and level of commitment.
4. It is very important that you inform me of any disease process from which you are suffering and any medications/ over the counter drugs that you are currently taking. Please advise me immediately if you are pregnant, suspect you are pregnant, or if you are breastfeeding.
5. While changes in dietary habits are not a prerequisite for treatment, failure to follow the recommended nutritional and exercise programs could undermine the expected results
6. You understand that it may take time to feel better when using natural medicine. You accept that positive changes will occur more rapidly with a higher degree of compliance with the recommended treatment protocol.
7. You are accepting or rejecting this natural medical care of your own free will and choice. You are free to withdraw your consent and discontinue treatment at any time.
8. If you have any questions regarding your treatment program, you will clarify these issues with your Homeopathic Doctor.
9. You are not an agent of any private, local, county, provincial or federal agency attempting to gather information without stating your intention to do so.
10. There are some slight health risks associated with treatment by Natural Medicine. These include but are not limited to:
-Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
-Some patients experience allergic reactions to certain supplements and herbs. Please advise me immediately of any allergies you may have.
11. 48 HOURS NOTICE is required for cancellation of appointments. Failure to do so will result in the patient being charged for the full amount of the visit.

_____ (Please Print),

HAVE READ AND UNDERSTOOD, AND I ACKNOWLEDGE THE ABOVE STATEMENTS.

PATIENT OR LAWFUL REPRESENTATIVE SIGNATURE _____