CELILO
NATURAL HEALTH CENTER LLC

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STATEMENT OF INFORMED PATIENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended allopathic as well as integrative and complementary procedures that are used to treat this condition. To inform you involves educating you whether the treatments and/or procedures recommended for this condition contain any risks or hazards. This education also involves informing you of the benefits that are involved in a treatment or procedure. This disclosure is an effort to make you better educated so that you may make an informed decision to give or withhold your consent for the treatment or procedure recommended.

NOTICE: Refusal to consent to the treatment or procedure should not affect your right to future care or treatment.

I voluntarily request Dr. Orna Izakson, ND as my naturopathic physician, to treat my condition(s). I understand that Dr. Izakson will review relevant procedures, risks and alternatives. I understand that any treatment caries with it unknowns or potential risks that I may not be made aware of. I understand that Dr. Izakson will do her best to inform me of any risks whenever possible. I understand that I may ask questions about any aspect of care. I understand that I can refuse treatment and or procedures at any time, and may discontinue this relationship at any time.

I understand that no warranty or guarantee has been made to me as to result of care. I understand that Orna Izakson N.D. is a naturopathic physician. It is important that I give her all my pertinent information in order to facilitate proper treatment and the best medical care possible. Reactions to treatment can be minimized when the doctor is carefully told about all medications I am on including prescription, herbal and over-the counter medications. I also understand that there is some risk of reaction to treatment that cannot be predetermined, and that it is important for me to contact the doctor immediately if a reaction occurs in order to remedy the situation as soon as possible.

I understand that Dr. Izakson does not treat prenatal or neonatal conditions. I understand she may only diagnose and treat after in-office visits, although general education and suggestions may be offered during telephone consultations.

I understand and agree to use prescribed alternative therapies as a complement to any treatment or therapy recommended by my medical doctor. I agree that I will not discontinue any medications or treatment without the approval of the prescribing doctor.

I certify this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

_____ _____

Patient/Guardian Signature Date