



# Desert Naturopathic Health

## Consent to Treatment

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_  
Today's Date: \_\_\_\_\_ Time: \_\_\_\_\_ am / pm

I, \_\_\_\_\_ (dated \_\_\_\_\_), hereby voluntarily consent to outpatient care at Desert Naturopathic Health, LLC, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.

I understand that the treatment suggestions provided are not all accepted by the United States FDA and therefore should not be taken as such.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Desert Naturopathic Health, LLC.

This form has been explained to me and I fully understand this *Consent to Treatment* and agree to its contents.

Comments:

\_\_\_\_\_  
\_\_\_\_\_

**Signature of Patient or Person Authorized to consent for patient:**

\_\_\_\_\_

**Signature of Witness who explained the contents of this "Consent to Treatment" form:**

\_\_\_\_\_