

Dr. Lise Maltais ND

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Declaration and Consent for Naturopathic Care

Welcome to the Naturopathic clinic of Dr. Lise Maltais. As a naturopathic doctor (ND) I will conduct a thorough case history, when warranted a physical exam and I often utilize specific blood, urinary or other laboratory reports as part of the treatment work-up. Integrate supportive therapies like Dietary Counseling, Herbal Medicine, Lifestyle Counseling, Homeopathy, Bowen Technique, Intravenous Therapy, Neural Therapy and Supervised Weight Loss Programs are used to assist the body's ability to heal and to improve the quality of life and health.

Statement of Acknowledgement

Printed name of patient: _____

As a patient of Dr. Lise Maltais, I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have complications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. Slight health risks of some naturopathic treatments include, but are not limited to:

- Temporary aggravation of pre-existing symptoms
- Allergic reaction to supplements and herbs

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient of Dr. Lise Maltais is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a MD, another ND or other healthcare providers.
- I understand results are not guaranteed.
- I understand that a record will be kept of my visits. This record will be kept confidential and will not be released without my consent unless your ND is required to do so by law.
- I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for payment at the time services are rendered. Dispensary items must be paid for in full before leaving the office.
- I am aware that **24 hours notice** must be given for all **cancelled appointments** or a **cancellation fee will be applied**.
- I understand that Dr. Lise Maltais reserves the right to determine which cases fall outside her scope of practice, in which case the appropriate referral will be recommended.

I consent to receive naturopathic treatment from Dr. Lise Maltais. I understand this consent is voluntary and I may withdraw consent to any further treatment and discontinue treatment at any time.

Signature of Patient/Guardian: _____ Date: _____
