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CONSENT FOR TREATMENT

I hereby authorize **Christopher Lepisto, ND** to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but not limited to blood, urine, saliva and stool lab work, general physical exams, neurological and musculoskeletal assessments.)

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions.

Herbs/Natural Medicines (prescribing of various therapeutic substances including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)

Soft Tissue and Osseous Therapeutics (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as non-chiropractic mobilizations of the extremities and spine including traction and craniosacral therapy.)

Electromagnetic and Thermal Therapies (includes the use of infrared and ultraviolet therapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical therapies; and aggravation of pre-existing symptoms.

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 Dr. Lepisto if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Christopher Lepisto, ND. 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 me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee. In the event of death, retirement or other cessation of Dr. Lepisto's practice, you may make a written request for your records to be received within a prompt and reasonable amount of time.

Patient/Guardian Initials ____ Date _____

State of Colorado Mandatory Disclosure Statement (Consent for Treatment Continued)

"Complaints regarding this Naturopathic Doctor must be submitted in writing to the Office of Naturopathic Doctor Registration. To obtain a complaint form, please contact the Division at (303)894-7414 or find more information how to file a complaint at: http://www.dora.state.co.us/reg_investigations/file_complaint.htm. Naturopathic Doctors are registered by the state to practice naturopathic medicine under the "Naturopathic Doctor Act." They are not permitted to perform the following acts:

☐ *Prescribe, dispense, administer or inject any prescription medications or devices other than epinephrine for anaphylaxis and barrier contraceptives (not including IUDs).*

☐ *Perform surgical procedures, including surgical procedures using a laser device.*

☐ *Use general or spinal anesthetics, other than topical anesthetics.*

☐ *Administer ionizing radioactive substances for therapeutic purposes.*

☐ *Treat a child who is less than two years old.*

☐ *Treat a child who is two years of age or older, but less than eight years of age, unless: (1) this form is fully completed and signed; (2) the most recent immunizations schedule recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services is provided to the parent or guardian with this form [obtainable on the website of Dr. Lepisto at www.grandjunctionnaturopath.com]; and (3) a release of information is provided to the parent or guardian requesting permission to exchange information with the child's licensed pediatric health care provider, if the child has one.*

☐ *Practice medicine, surgery, or any other form of healing other than Naturopathic Medicine.*

☐ *Practice obstetrics.*

☐ *Perform chiropractic services (spinal adjustments, manipulation, or mobilization). Physical medicine, as described in § 12-37.3-102(12)(b), C.R.S., is permitted.*

☐ *Recommend the discontinuation or counsel against a course of care, including a prescription drug that was recommended by another health care practitioner licensed in Colorado, unless the Naturopathic Doctor consults with the health care practitioner.*

1. *I, Christopher Lepisto, am a Naturopathic Doctor registered under Title 12, Article 37.3, of the Colorado Revised Statutes.*

2. *I am not a medical doctor or a physician licensed under Title 12, Article 36, of the Colorado Revised Statutes.*

3. *I recommend that the patient named below have a relationship with a licensed physician, or if the patient is a child aged two to seven, with a licensed pediatric health care provider.*

4. *If the patient is a child aged two to seven, I recommend that that the child's parent or guardian follow the immunizations schedule that accompanies this form.*

5. *If the patient has a relationship with a licensed physician or pediatric health care provider, I will attempt to develop and maintain a collaborative relationship with the physician or pediatric health care provider. To permit this, the patient (or patient's parent/guardian if patient is a minor) will need to sign a separate release allowing me to exchange information with the licensed physician or pediatric health care provider.*

(Naturopathic Doctor Signature) **Patient/Guardian Initials ___ Date _____**

State of Colorado Mandatory Acknowledgement (Consent for Treatment Continued)

(The following is to be completed by the adult patient, or parent/guardian if patient is a minor)

I, _____ (print adult patient's name, or if the patient is a minor, the parent or guardian name), acknowledge receipt of the above disclosure statement and give my informed consent for treatment for (circle one) ***myself*** *or* ***my child****, _____ (print patient's name) by the above named naturopathic doctor.*

Check one:

This patient ___ does ___ does not have a relationship with a licensed physician or pediatric health care provider.

Name, address, phone of licensed physician or pediatric health care provider:

_____
_____
_____"

Disclosure of Cancer Treatment Requirements

If you or the patient for whom you are the legal guardian are seeking treatment for cancer, or currently have or at any subsequent time found to have a diagnosis of cancer for which you are seeking treatment, I am by law required to recommend that the patient consult with a physician in oncology and document that recommendation in writing.

I acknowledge the disclosures on this and all previous pages. I consent to treatment by Christopher Lepisto, ND. (Please sign either the left or the right column below.)

_____ _____
Guardian/Personal Representative's Name (PRINT) Patient's Name (PRINT)

_____ _____
Guardian/Personal Representative's Signature Patient's Signature

_____ _____
Relationship/Representative's Authority Date

_____
Date