



**NATUROPATHIC MEDICINE
INFORMED CONSENT FOR CONSULTATION**

I, _____, hereby authorize The Naturopathic Health Clinic of North Carolina (NHCNC) and John (Keoni) Teta and Jade Teta to act as natural health consultants on my behalf (or my child). I understand that The NHCNC, John (Keoni) Teta, and Jade Teta do not diagnose nor treat any condition or conditions, that they ARE NOT licensed healthcare providers in the state of NC, and that if I choose to follow through with any recommendations set forth by NHCNC, John Teta or Jade Teta I should consult with my physician first.

Furthermore, I understand the following:

NHCNC does not offer diagnosis for any condition or conditions

NHCNC does not offer treatment for any specific condition or conditions

NHCNC does attempt to restore balance to the whole body by analyzing the negative environmental stimuli (food, movement, air, water, light, sleep, etc) that may be blocking the way to healing and optimal health. NHCNC uses the following modalities to that end:

Therapeutic nutrition

Life Coaching

Energetic Psychology

Homeopathy

Acupuncture

Metabolic and Functional Profiling

Stretching and structural correction

Therapeutic exercise

Balneology

Hydrotherapy

Botanical Medicines

I recognize the potential risks and benefits of the procedures above and have had them all explained to me to my full satisfaction:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of dis-ease, assistance in injury and dis-ease recovery, and prevention of disease or its progression.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by NHCNC, John (Keoni) Teta, and Jade Teta or any of their affiliated personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health consultation provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my consultation record at any time and can request a copy of it by paying the appropriate fee. I understand that my consultation record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my consultation record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my consultant to the best of his/her ability.

Date

Original to: Chart

Copy to: Client (if requested)

Signature of Client

Signature of Client Representative or Guardian