



Date Completed: \_\_\_\_\_

MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

Main Campus: 3025 SW Corbett Ave. Portland, OR 97201  
NUNM Information Center: 503-552-1551

## NATUROPATHIC MEDICINE, CLASSICAL CHINESE MEDICINE, AND NUTRITION CONSENT TO ESTABLISH CARE

Informed consent is a process, not a form, and involves an ongoing, interactive dialog between you and your provider. The process of informed consent occurs when communication between you and your provider results in your authorization or agreement to undergo a specific medical intervention.

I do hereby give my consent to services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient of the National University of Natural Medicine (NUNM) Health Centers. I understand that patient care is directed by licensed health care providers who are employees of NUNM. I consent to services rendered to me under the instructions of these professionals, as well as volunteer staff physicians who may be associated for the purpose of consulting.

I recognize that NUNM is a teaching institution. I agree that persons who are students and resident physicians will participate in my care as part of the educational programs of the institution. I hereby request and consent to examination and treatment with the providers, students, and affiliated providers at NUNM Health Centers.

I understand I have the right to ask questions and discuss to my satisfaction with the above mentioned providers and/or students:

- My suspected diagnosis(s) or condition(s)
- The nature, purpose, goals, and potential benefits of the proposed care
- The inherent risks, complications, potential hazards, and/or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done

I understand that evaluation and treatment may include, but is not limited to:

- **Common diagnostic procedures** (including but not limited to physical examination, laboratory testing of blood and other bodily fluids, electrocardiogram, lung function testing, ultrasound, and referrals for external diagnostic procedures).
- **Soft tissue treatment** (including but not limited to massage, neuro-muscular technique, and muscle energy technique) and naturopathic osseous manipulation of the spine and extremities (see Physical Medicine treatment section below for detail).
- **Dietary and therapeutic nutrition recommendations and counseling** (including but not limited to the use of foods, individualized diet plans, nutritional supplements, and parenteral (intravenous or intramuscular) vitamin injections (see separate Parental Injection consent below).
- **Trigger point injection/Prolotherapy** with or without vitamin substances.
- **Natural substance prescriptions** (including but not limited to plant/herbal, mineral or animal-based substances in full strength or highly diluted/homeopathic). Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams, pastes, plasters, washes, or other forms.
- **Counseling** (including but not limited to mindfulness techniques, behavioral change, stress management techniques, and tobacco/substance use cessation).
- **Over-the-counter and prescription medications** (including only those medications listed on the Oregon Board of Naturopathic Medicine formulary).



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**INFORMED CONSENT AND REQUEST FOR CARE (CONTINUED)**

- **Hydrotherapy** procedures (including but not limited to alternating hot and cold applications, baths, sauna, ice, towels and/or sheets , electrical stimulation, ultrasound and diathermy) and other therapies. Possible risks and complications associated with these procedures may include:
  - Mild skin burns or irritation
  - Overheating
  - Skin rash
  - Dizziness
  - Temporary decrease in blood pressure
  
- **Classical Chinese medicine** procedures including, but not limited to acupuncture, moxibustion, cupping, electro-acupuncture, herbology, and massage. Possible risks and complications associated with these procedures may include:
  - Slight burns
  - Nausea
  - Infections and blisters
  - Fainting
  - Scarring
  - Bruising
  - Bleeding
  - Tingling/soreness near needling sites that may last a few days
  
- **Physical medicine** treatments including examination, diagnostic procedures, manipulation and/or mobilization of the neck, spine, and extremities involving movement of the joints and soft tissues, and soft tissue therapies (specifically: manual soft tissue therapies, instrument-assisted soft tissue mobilization (IASTM), percussion/vibration therapy and therapeutic tape procedure). Physical therapy, including exercise, electrical stimulation, hot/cold therapies, ultrasound, diathermy, TENS units, low-level laser therapy, traction, and other therapeutic modalities recommended for my condition may also be used. Possible risks and complications associated with these procedures may include:
  - Soreness
  - Muscle spasms
  - Temporary increase in symptoms
  - Sprains and strains
  - Dizziness
  - Fractures/joint injury
  - Mild to moderate bruising
  - Physical Therapy burns (rare)
  - Stroke (has been rarely reported to occur specifically from neck manipulation)
  
- **Parenteral Injection (Intravenous [IV] and Intramuscular) Therapy** treatments including drips, pushes, and IV chelation (heavy metal detoxification). This treatment involves inserting a needle and injecting a standardized formula into veins or muscles. Possible risks and complications associated with these procedures may include:
  - Pain, bruising, or infection at injection site
  - Inflammation of vein used for infusion (phlebitis)
  - Severe allergic reaction or anaphylaxis, resulting in cardiac arrest, possibly death

**Alternatives to IV Therapy include:**

- Oral supplementation
- Lifestyle and dietary change

I understand that some medicines, supplements and procedures may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform my provider or student so that my treatment plan may be re-evaluated.

*\*Please note:* There are additional consent forms for Parenteral injections or chelation therapy (IV Therapy), minor surgery, hormone treatments and other special procedures or services.

*I have fully read and understand the above and hereby consent to services.*

\_\_\_\_\_  
Signature of Patient Date

\_\_\_\_\_  
Signature of Parent/Guardian (if Patient is under 15) Date