



Jim Harris

Nutritional Consultant

INFORMED CONSENT FOR NUTRITIONAL TREATMENT AND CARE

This document provides important information regarding the services being provided and should be carefully reviewed. Please ask any questions you have regarding services before signing this document.

SERVICES

Jim Harris offers a variety of naturopathic services. These services are individualized to meet your personal needs. He has a Doctor of Dental Surgery degree and also has earned the degree of Doctor of Naturopathic Medicine.

Jim is not a traditional medical doctor nor does he portray himself to be one and to that end he is not a licensed physician in the State of California. He does not diagnose disease, offer prescription drugs, surgery or other conventional treatments. Jim offers applied kinesiology testing, biofeedback, nutritional supplementation and lifestyle consultation along with various methods of testing.

Your first visit will involve an evaluation of your current lifestyle and your nutritional needs. At the time of your evaluation, it is necessary you supply him with all applicable healthcare information, past and present.

Nutritional treatment is unique in that when an appropriate holistic treatment plan is followed, disease symptoms usually diminish and overall health improves. In order for the treatments to be most successful, you will need to follow your recommended treatment plan and keep your regularly scheduled appointments.

PROFESSIONAL FEES AND PAYMENT

The visit lengths depend upon the complexity of the health concerns. Establishing initial care as a new client takes place with the first visit lasting 60 to 120 minutes. Return visits are 25 minutes minimum. See the "Financial Agreement" form for the current fee schedule. For follow up care, recommended visits may be weekly, bi-weekly or monthly for acute conditions and quarterly for chronic conditions. Fees may apply for telephone conversations or for requested additional work.

All payments are due at the time of service. We accept checks, cash, Visa or MasterCard. You are asked to provide us with a credit card number at your initial visit and authorize its use for billing purposes if you do not pay by cash or check. With this authorization, we will reserve an appointment time specifically for you. Once an appointment is scheduled, you are expected to pay the full visit fee for that visit. *If you are not able to provide 24 hours advance notice of cancellation, you will be charged the full visit fee.*

We do not accept insurance payment nor do we bill insurance providers or provide you with insurance forms. We cannot guarantee that your insurance provider will cover any fees. Please contact your insurance provider directly for specific information on your coverage.

CONTACTING OUR OFFICE

Jim is often not immediately available by telephone. Messages left with the receptionist or on the office voice mail system will be given to him as soon as he is available. We will make every effort to return your call in a timely manner. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and your needs are of an urgent nature, contact urgent care or the nearest emergency room. If we are unavailable for an extended period of time, we will provide you with the name of a colleague to contact, if necessary.

I, _____ (Client's Name OR Name of Parent/Guardian) have read and understand the above information. I hereby request and consent to nutritional care on me (or on the client named below, for whom I am legally responsible) provided by Jim Harris.

I understand that methods or treatment may include but are not limited to herbal medicine, lifestyle counseling, clinical nutrition, biofeedback, applied kinesiology and homeopathy. I have had an opportunity to discuss with Jim the nature and purpose of naturopathic treatments and other integrative or complementary procedures.

Those treating with nutrients understand the body has an innate ability to heal itself and use the least force necessary to bring about a healing response. Because of this, the risks associated with the services offered through us are generally low. However, I am aware that all existing methods of diagnosis and treatment, including nutritional supplementation, pose some level of risk. The possible outcomes of these practices can range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of nutrition, however, some supplements may be toxic in large doses. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will notify the doctor if I am or become pregnant.

I will inform the office if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting), allergic reactions (hives, rashes, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the herbs or other supplements dispensed by him. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

CONTINUE ON REVERSE SIDE



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I do not expect to be able to anticipate and explain all risks and complications, and I wish to rely on Jim to exercise judgment during the course of the procedure which he feels at the time, based upon the facts then known, is in my best interests. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review any medical records and lab reports, but all my records will be kept confidential and will not be released without my consent.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

CLIENT SIGNATURE _____ **Date:** _____
(or Client Representative)

Indicate relationship if signing for client _____