



# SOUND NATURAL MEDICINE

284 Central Way - Kirkland, WA 98033

## Informed Consent

I, the undersigned, voluntarily consent to receive healthcare from a Naturopathic Physician at Sound Natural Medicine. I understand that there are intrinsic differences between the care of Naturopathic Physicians and Medical Doctors and it is my decision to pursue naturopathic care for any medical condition I may have. I hereby authorize my Naturopathic Physician to perform diagnostic testing and therapeutic procedures as may be necessary for my healthcare. I recognize the potential risks associated with these diagnostic tests and therapeutic procedures including allergic reactions, side effects of prescriptions, inconvenience of treatment recommendations, and unforeseen injury from procedures.

I understand that as with all medical treatment, there is no guarantee that treatment provided or any treatment will offer a complete resolution to any or all medical conditions I may have.

I understand that Sound Natural Medicine will keep a record of the healthcare services provided to me. This record will be kept confidential and will not be released to others unless so directed by my legal representative or myself or unless required by law.

Patient/Guardian Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_

**Sound Natural Medicine**  
284 Central Way  
Kirkland, WA 98033  
425-803-9574

SEE REVERSE