NW Olive Clinic LLC
Natural Medicine and Primary Care

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Informed Consent for Naturopathic Medical Care

As a patient, I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Sabah Targhi, having had the opportunity to discuss the potential benefits, risks and hazards involved.
I _____, hereby request and consent to examination and treatment with Naturopathic Medicine with Dr. Sabah Targhi and/or other licensed naturopathic doctors serving as backup for her, hereafter called allied health care providers.
I understand that I have the right to ask questions and to discuss my satisfaction with Dr. Sabah Targhi, and/or with the allied health care provider providing backup:
(1) My suspected diagnosis (es) or condition(s)
(2) The nature, purpose, goals, and potential benefits of the proposed care
(3) The inherent risks, complications, or side effects of treatment or procedure
(4) Reasonable available alternatives to the proposed treatment procedure
(5) Potential consequences if treatment or advice is not followed and/or nothing is done
(6) I understand that a Naturopathic evaluation and treatment may include but are not limited to: Physical exam. Evaluation of lab results and imaging results. Dietary counseling and lifestyle strategies. Recommending oral and topical supplements/remedies. Homeopathic remedies (highly diluted quantities of naturally occurring substances). Over the counter and prescription medications (including only those medications on the Formulary of the State of Washington Naturopathic Physicians)

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pacemaker, and/ or cancer: For your safety, it is vital to alert Dr. Sabah Targhi, of these conditions.

Please understand the following:

- I understand that Dr. Sabah Targhi is not licensed to prescribe any controlled substances.
- I understand that Dr. Sabah Targhi, will only prescribe medications if she believes that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.
- I understand that the US Food and Drug Administration has not approved nutritional, herbal, and homeopathic substances; however, these have been used widely in Europe, China and USA for years.
- I do not expect Dr. Sabah Targhi, and/or any allied health care provider to be able to anticipate and explain all the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is

my responsibility to request Dr. Sabah Targhi to explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of service has been made to me concerning the results intended from any treatment provided to me. By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

Statement of financial responsibility

I understand and agree to the following general responsibilities:

- Financial options extended to me are based on the personal identification
- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service.
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize NW Olive Clinic/Dr. Sabah Targhi to release information necessary to secure payment.
- I understand that there will be a minimum $50 fee for any appointment not cancelled within 24 hours of the scheduled appointment.

I understand and agree to the following with regards to current and/or future insurance billing:

- The verification of my health insurance is used to determine if there are coverage services through my insurance carrier and is not a guarantee of payment by my insurance; I am fully responsible for being aware of any coverage exclusion
- I am responsible of providing in a timely manner all accurate, current information and documentation required to verify my insurance coverage and/or bill my insurance, including all relevant coordination of benefits information such as primary and secondary insurance, Medicare, Medicaid, etc.
- I am responsible for full and timely payment of all insurance co-pays, deductibles, and co-insurance balances due, including all services not covered or paid by my insurance
- I am responsible for full payment of all services if any of the information I have provided is incorrect, falsified and has results in NW Olive Clinic inability to directly bill for services reimbursement from my insurance.
- I may forfeit the privilege of billing my insurance if I don't comply with any of my financial reasonability or documentation requirement
- I authorize release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to NW Olive Clinic. This release applies to support of the insurance billing process only. Separate authorization may be required for other entity requests.

I have fully read and understand the above agreements and authorization

Patient Name (printed): _____ Signature: _____ Date: _____

Name of Guardian (Printed): _____Signature of Guardian:_____Date: _____