Dr. Julia Parke, ND
1619 Beagle Ct
Ventura, CA 93003

INFORMED CONSENT FOR NATUROPATHIC CARE

I, _____, hereby engage and authorize Dr. Julia Parke, ND to treat, administer, and provide health care to myself.

I understand that the herbs, nutritional supplements, and homeopathic remedies are natural substances to support my body systems. The usefulness of these preparations has not been approved or disapproved in the United Sates. I agree to inform Dr. Julia Parke, ND immediately if any adverse reactions develop while I am taking these substances.

I recognize the potential risks and benefits of these substances as described below:

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 disease, assistance in injury and disease recovery, and prevention of disease or its progression.

With this knowledge, I voluntarily consent to treatment to be determined based on my particular needs, realizing that no guarantees have been given to me by Dr. Julia Parke, ND regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue treatment at any time.

Accordingly, I sign this Informed Consent, to express that it is my own decision without undue persuasion to be treated by Dr. Julia Parke, ND with naturopathic medical care. I hereby release Dr. Julia Parke, ND and its employees from liability for any results that may occur to me thereafter.

I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical 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 any questions I have will be answered by Dr. Julia Parke, ND to the best of her ability.

Dr. Julia Parke, ND
1619 Beagle
Ct
Ventura, CA 93003

_____
Printed name of Patient

_____ _____
Signature of Patient (*or guardian if minor*) Date

_____ _____
Witness to Patients' Signature Date