Karen Ball, ND
DrBall@DrKarenBall.com
425-318-0255

INFORMED CONSENT

Treatment
I understand that Dr. Ball is a licensed naturopathic doctor specializing in natural medicine. I give consent to this form of treatment. I will ask the doctor to explain when I do not understand a treatment. I am aware that any type of treatment from conventional, natural or other types of medicine may have side effects. I will inform the doctor of any known allergies, and provide previous medical history as necessary.

_____ _____
Signature of patient, guardian or personal Representative Date

Payment
I agree to pay for any fees for services, costs of supplements and remedies, costs of laboratory tests, or other costs or fees that are not covered by my insurance plan.

_____ _____
Signature of patient, guardian or personal Representative Date

Notice of Privacy Practices
I have received notice of privacy practices. I consent to the use of my personal health information for the purposes of treatment, payment and clinic healthcare operations. I am aware that a detailed description of the privacy policy of this clinic is available upon request and that a copy of the detailed privacy policy is posted in the clinic reception area.

_____ _____
Signature of patient, guardian or personal Representative Date