SEASONS NATURAL HEALTHCARE, LLC
CORA RIVARD, ND
(603)736-7770

Informed Consent for Treatment

I _____, hereby authorize Seasons Natural Healthcare, LLC, to provide naturopathic medical care to me, including diagnostic, therapeutic and other services necessary to facilitate my diagnosis and treatment. I understand that these services may include, but may not be limited to the following:

- Therapeutic use of nutrition and nutritional supplementation
- Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, or suppositories
- Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses
- Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities
- Manual therapies, including myofascial release, craniosacral therapy, and structural integration for the purpose of relieving pain and improving muscle and joint functions

I am aware that with the guidance of the doctor, I may choose to be an active partner in helping determine my treatment plan, and I will ask the doctor to explain when there may be a treatment that I am unfamiliar with or do not understand. I am aware that any type of medicine, conventional or naturopathic, may have potential for side effects. I will inform the doctor of any known allergies and provide previous medical history as necessary.

Notice to Pregnant women: All female patients must alert the naturopathic doctor if they know or suspect that they are pregnant. Some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the provision of treatment to me by Seasons Natural Healthcare, LLC, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue my treatment at any time.

Date:_____

Signature of Patient:_____

Signature of Patient's Parent, Representative or Guardian_____
(required if patient is younger than 18 years old)