



Whole Health Concord

Naturopathic Medical Center

Dr. Laura Riley

Consent To Treatment

Today's Date:

Patient Name:

Date of Birth:

I voluntarily consent to outpatient care at Whole Health Concord, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), and administration of medications prescribed by the doctor.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.

I understand that not ALL of the treatment suggestions provided are accepted by the United States FDA and therefore should not be taken as such.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Whole Health Concord.

This form has been explained to me and I fully understand this *Consent To Treatment* and agree to its contents.

Comments:

Signature of Patient or Person Authorized to consent for patient: _____

If the patient is a minor or is unable to consent, please complete the following:

- Patient is a minor and is _____ years of age.
- Name of Father
- Name of Mother
- Patient is unable to consent because

Signature of Closest Relative or Legal Guardian

Please Print Name

Relationship:

Witness to Signature: _____

Whole Health Concord

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