MAINE NATURAL MEDICINE

Empowering Health™

Terms of Consent for Care

I, ____________________________, hereby authorize Dr Sachsman to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, radiology, laboratory, x-ray
Minor office procedures: e.g., cleaning, dressing a wound, ear lavage, skin scraping
Medical use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Botanical medicine: plant substances may be prescribed as teas, alcohol-based tinctures, glycerites, capsules, tablets, creams or suppositories
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals
Integrated Awareness, Visceral Manipulation: gentle energetic forms of bodywork used to address pain musculoskeletal complaints, headaches, organ dysfunction and emotional balancing

I recognize the potential risk and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Please notify Dr Sachsman's office if your child experiences any symptoms which may be secondary to the above procedures.

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or it's progression.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by physician, or any personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to my child. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my child's medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my child's medical record will be kept for a minimum of three, but no more than ten years after the last day of my visit. I understand that information from my child's medical record may be analyzed for research purposes, and that my child's identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

I understand that all sales of goods and services are final.

____ ____________________

Signature of Patient Date

____

Signature of Patient Representative or Guardian

MARLY SACHSMAN, ND, MA-CCC
Naturopathic Doctor | Speech/Language Pathologist | Integrated Awareness® Teacher | Institute for Integrative Nutrition Certified
MENATURALMED.COM drsachsman@menaturalmed.com | 207 664 0005 | 63 Foster Street, Suite 2, Ellsworth, Maine 04605