Dr. Anne Christine Hicks, NMD
Upaya Naturopathic Wellness, PLLC

Patient's Consent to Treatment and Financial Agreement

I voluntarily consent to outpatient care at Nordic Naturopathic, 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 injections & medications prescribed by the doctor. I understand that some treatments are considered experimental and that some treatment suggestions provided are NOT accepted by the United States FDA. I therefore, hereby release Dr. Anne Christine Hicks, NMD and Upaya Naturopathic Wellness, PLLC, from any liability arriving out of the status of the approval or lack of approval of these therapeutic processes.

I understand is I must inform Dr. Hicks immediately of any disease process that I am suffering from, any prescription medication or over the counter drugs I am taking, or supplements I am using. If I become pregnant, or suspect I am pregnant, I will advise Dr. Hicks immediately.

There are some health risks to treatment. These include but are not limited to:
- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, dizziness, or injury from venipuncture, acupuncture or injections.
- Fainting or puncturing of an organ with injection therapy needles.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. 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. _____Initials

I understand that the Naturopathic Medical Doctor will answer any questions that I have to the best of her ability. I understand that treatment instructions/procedures and any possible side effects will be explained to me. I do not expect the doctor to be able to anticipate and explain all risks and complications. _____Initials

I understand that charges are to be paid at the time of the visit, including cost of consultation and diagnostic labs to be ordered. Payments for all dispensary items (supplements/pharmaceuticals/hormones) are due at the time of the visit. _____Initials

I understand all supplements made available to purchase through Upaya Naturopathic Wellness, PLLC, are not required and are provided only for my convenience. Agreeing to purchase any supplement at the clinic or through online purchasing is voluntary, and does not imply a contract for maintenance with Dr. Hicks or Upaya Naturopathic Wellness, PLLC. I am free to purchase supplements at any outlet I choose and do not have to buy or consume any products that Dr. Hicks might recommend during a consultation. _____ Initials

I have read and understood the above stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (Please Print) ____

Signature of Patient or Guardian: ____________________________________ Date: __________________

_________________________ Dr Christine Hicks, NMD