NEW HORIZONS NATUROPATHIC CLINIC
Dr. Clinton M Pomroy, ND
5308 Derry Ave., Suite K
Agoura Hills, CA 91301

Informed Consent Form

I, _____(or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor or New Horizons Naturopathic Clinic, whether signatories to this form or not. I have also read, signed, and understand the ARBITRATION AGREEMENT, and the NOTICE OF PRIVACY PRACTICES**.**

Notice to Cancer Patients: We do not treat cancer. We treat underlying conditions (such as nutritional, hormonal, toxin imbalances) that impair or significantly weaken the immune system to be able to respond to cancer. Support and therapies given are aimed at restoring the immune system to full function.

Notice to Women: all female patients must inform the doctor if they know, suspect, or may be pregnant, as some of the therapies used could present risk to the pregnancy and fetus.

I understand that the methods of treatment may include but are not limited to:
nutritional counseling, EAV (electrodermal screening), western herbs, chinese herbs, counseling, prescription medications, homeopathy, nutritional supplements, oral chelation, IV chelation, IV therapy (nutritional and natural substances), hydrotherapy, injections (intramuscular, subcutaneous, intradermal, intraoral, intranasal, intra-articular, intra-tendonous, intra-ligamentous), prolotherapy, neural therapy, prolozone, neural prolotherapy, stem cell therapy, hydrotherapy, ultrasound diagnostics and therapy, diagnostic imaging, diagnostic procedures, minor surgery, physical medicine, far infrared sauna, laser and light or sound therapy, and hyperbaric oxygen therapy. I understand that all treatments, whether those listed above or any others, will be discussed with me before treatment begins and I am encouraged to ask questions that my doctor will respond to.

I have had the opportunity to discuss, with the naturopathic doctor named above, the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal. Further potential risks include allergic reactions to prescribed supplements, medications, and herbs, which may be severe such as anaphylaxis, cardiac arrest and death. Side effects from and between natural medications and pharmaceuticals, inconvenience of lifestyle changes, aggravation of present conditions, injuries such as pain, discomfort, discoloration, and pneumothorax from injections, venipuncture, soft tissue or bony injury from physical manipulation and other procedures can occur.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources), prescriptions and treatments that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. I am aware that it is extremely important that I follow the prescribed recommendations when taking any prescriptions, herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that following all instructions, whether orally and or in writing, help to improve outcomes of treatment. I understand that some herbs, medications, supplements, diets, or treatments may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements or any treatments prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. I understand that in order to properly treat my medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises for any reason due to treatment from my naturopathic doctor or any other reason, it is clear to me that I am to seek treatment immediately from a trauma center or call 9-1-1.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment in recommending the treatments that the doctor feels at the time, based on the facts then known, are in my best interest. I have had the opportunity to ask questions and discuss with Dr. Pomroy, and/or an allied health care provider, to my satisfaction:

- potential benefits of seeking care with Dr. Pomroy which include restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease and disease itself, and prevention of disease and its progression.
- my suspected diagnosis or condition
- the nature, purpose and potential benefit of the proposed care
- the inherent risks, complications, potential hazards, or side effects of the treatment or procedure
- the probability or likelihood of success
- reasonable available alternatives to the proposed treatment / procedure
- the possible consequences if treatment or advice is not followed and/or nothing is done.

With this knowledge, I voluntarily consent to the above procedures realizing that no guarantees have been given to me by **Dr. Pomroy or New Horizons Naturopathic Clinic,** or any of its personnel, regarding cure or improvement of my condition. I understand that I am free to withdraw my consent for future treatments at any time but discontinuing consent does not remove past consent for therapy or treatments already consented to, or participated in with Dr. Pomroy or other personnel at NHNC.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below, I

agree to the above-named procedures and to any others that are discussed with me, based on my naturopathic doctors recommendations. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment, until consent is discontinued.

PATIENT NAME,
(printed)_____

PATIENT SIGNATURE, _____ **Date:**_____
(or Patient Representative)
Indicate relationship if signing on behalf of patient _____

Additional Treatments or Therapies reviewed and discussed with my naturopathic doctor:

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