DR HOLLI GOWER, 525 GLEN CREEK RD NW, SUITE 230 SALEM, OR 97304 503-339-7376

Informed Consent For Treatment

I, the undersigned hereby authorize DR. HOLLI GOWER, to perform the following specific procedures necessary to facilitate my diagnosis and treatment. Medical treatments and procedures not within license of scope practice will be referred out to an appropriate provider.

Common Diagnostic Procedures: e.g., venipuncture, pap smears, laboratory, diagnostic imaging.

Minor Office Procedures: e.g. dressing wound, ear cleaning, gynecological exams.

Botanical Medicine: botanical substances may be prescribed as teas, alcohol-based tinctures, capsules, tablets, creams, plaster poultices, compresses 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: nutrition therapy and promotion of wellness, including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

Psychological Counseling

Contraception Counseling: oral birth control pills, IUDs, diaphragms, etc.

Legend substances: pharmaceutical agents approved for prescription by naturopathic physicians.

Intravenous nutrition/chelation: introduction of vitamins, minerals and/or chelating agents for the promotion of detoxification and/or general health.

I recognize the potential risks and benefits of these procedures as described below.

Potential risks: discomfort, pain, infection and blistering at the site of procedure, temporary discoloration of the skin, an aggravation of symptoms existing prior to treatment, allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from needle insertion, injections, venipuncture or other procedures.

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

With this knowledge, I voluntarily consent to the above procedures, realizing that DR. HOLLI GOWER has given no guarantees to me, regarding cure or improvement of my condition. I hereby release DR. HOLLI GOWER, from any and all liability, which may occur in connection with the above-mentioned procedures except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. Any cancellation must be within 24 hours prior to the scheduled appointment to avoid charges for the visit.

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 unless so directed by my representative or myself, or unless required by law. I understand that I may look at my medical records and request a copy of it by paying the appropriate fee. I understand that my practitioner will answer any questions I have.

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Signature of Patient or Guardian Date

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Print Name of Patient