Integrative Family Medicine of Bend

Informed Consent

WELCOME TO INTEGRATIVE FAMILY MEDICINE OF BEND

Thank you for choosing Integrative Family Medicine of Bend as your primary care home. We seek to provide you and your family with the most powerful and supportive combination of care available by using both conventional and alternative medicine.

You play an integral role in your own health and in the management of your care. As a new patient, we want to inform you of how we will protect your private information, make you aware of the responsibilities you are taking on, and ask for your consent to treat you. Please read the following forms carefully and make you sure you understand them before signing.

We look forward to addressing your health needs. We encourage your questions and participation in all aspects of your health care.

Informed Consent and Consent for Treatment

In this document, "I" and "me" refers to the patient whose signature is below:

I hereby authorize and request evaluation, diagnosis, and treatment services from the physicians (“Physicians”) of Integrative Family Medicine of Bend (IFM Bend). I understand that the services may include, but are not limited to:

- Physical exam for both routine wellness or diagnostic purposes
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intramuscular vitamin injections)
- Botanical/herbal medicines given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Compounded medications
- Counseling
- Over-the-counter and prescription medications

I recognize that I have a right to be informed about my condition and recommended care. This Consent is to help me become better informed about potential treatments so I may give, or withhold, my consent after discussing my condition. I acknowledge that the information provided by this Consent is necessarily general, and I shall always have the right and am encouraged to discuss proposed treatments in further detail with my Physicians. I always have the right to discuss the potential benefits, risks, side effects, or hazards of any treatment; to inquire about the likelihood of success of any treatment; and to discuss alternative treatment options or the potential consequences if treatment or advice is not followed or nothing is done.

I understand and I am informed that in the practice of naturopathic medicine there are risks and benefits with evaluation, diagnosis and treatment including, but not limited to the following:

Potential risks: allergic reactions; side effects; adverse interactions with other therapies; inconvenience of lifestyle changes; or injury or infection from injections, venipuncture, medical devices, or other procedures. IFM Bend follows universal precautions for infection prevention. These precautions greatly reduce, but do not fully eliminate, the risk of a healthcare acquired infection.

Potential benefits: restore health and the body’s maximal functional capacity; relieve pain or symptoms of disease; injury or disease recovery; and prevention of disease or its progression.

Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

I acknowledge that I have been provided ample opportunity to read and understand this document. I have had any questions satisfactorily answered. I am legally competent to sign this document. If I am signing on behalf of the patient I warrant that I am authorized to act as the patient’s legal guardian or health care attorney in fact. If I provide a digital signature, I attest that I am signing the document via a secure patient portal, that I am the person signing, and that I intend for my signature to hold the same validity as a paper signature.

I understand the information regarding the potential risks and benefits of treatment. With this knowledge, I voluntarily consent to treatment, acknowledging that no expressed or implied guarantees have been made to me by IFM Bend, the Physicians, or any affiliate physician or staff regarding cure or improvement of my condition. I also realize that my practitioner(s) cannot anticipate and explain every possible risk or complication, and I wish to rely on the practitioner to exercise judgment during any of the above procedures and in recommending any other treatments for my condition(s).

I understand that any treatment or advice provided to me as a patient of IFM Bend is not mutually exclusive from any treatment or advice that I may be receiving now or in the future from any other health care provider. I understand that I am at liberty to seek or continue medical care from another provider and that no physician or employee of IFM Bend is recommending that I refrain from seeking or following the advice of another provider.
I am free to ask for further information at any time.

I understand the above and give my consent to the evaluation and treatment, including the entire course of treatments for my present condition and any future conditions for which I seek treatment. I also understand that I am free to withdraw my consent and to discontinue participation in these medical services at any time.

Signature ____________________ Date __________