The Healing Joint

Jeanette Musset, NMD

This is a confidential record of your medical history and will be kept in this office.
The information it contains will not be released to an person without your authorization.

Consent to Treat

Name: _____

Date of Birth: _____

I understand that this is a Naturopathic Medical Clinic, and I give consent to this form of treatment. I understand that a Naturopathic Doctor is a physician who specializes in natural medicine. I am aware that with the guidance of the doctor, I may choose to be an active partner in helping determine my treatment plan, and I will ask the doctor to explain when there may be a treatment that I am unfamiliar with or do not understand. I am aware that any type of medicine, conventional or otherwise, may have potential side effects. I will inform the doctor of any known allergies and provide previous medical history as necessary.

I hereby request Naturopathic Medicine treatment and therapies, including nutritional consultations and other procedures, including various modes of physiotherapy, nutritional therapy (including IV or IM injections if indicated) and diagnostic procedures, including laboratory testing, on me (or the patient named for whom I am legally responsible) by a Doctor of Naturopathic Medicine and/ or licensed doctors of Naturopathic Medicine who now or in the future treat me while employed by, working or associated with, or serving as back-up doctor in the offices of The Healing Joint. I also understand that Naturopathic Interns working under the doctor's direct supervision or the RN employed by the doctor may be directed by the doctor to perform certain diagnostic or therapeutic procedures on me during the time of my care.

Printed Name of Patient: _____

Patient/ Guardian Signature: _____

Date: _____

Financial Agreement

I claim full financial responsibility for services rendered by The Healing Joint and understand that full payment is required at the time of service.

Printed Name: _____

Signature: _____

Date: _____

Cancellation/ No Show Policy

I understand that The Healing Joint requires a 24 hour cancellation notice for all appointments. I understand that my failure to furnish notice will result in a charge of $30, which must be paid in advance of making a replacement appointment.

Printed Name: _____

Signature: _____

Date: _____