



consent for care

I, _____, hereby grant permission to Natural Flow and its clinicians to perform such examinations and therapeutic treatments as are considered necessary or advised for my diagnosis and treatment plan. Clinicians who treat me include, but are not limited to: naturopathic physicians, colon hydrotherapists, chiropractors, acupuncturists, massage therapists, and psychologists.

I understand that a record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may look at my medical record at any time and can request a copy of it.

I understand that the nature of the recommended medical treatments for my care will be explained to me. I understand that I will have the opportunity to ask questions of those involved in my care. I am not being forced by anyone to accept medical treatment.

Payment Agreement

I assume full responsibility for and agree to pay all costs, charges and expenses of every kind and description for services rendered by Natural Flow. The amount of the bill shall be due and payable upon time of service.

Cancellation Notice

Please respect our 24 hour notice of cancellation. Appointments cancelled in less than 24 hours from your scheduled time or clients who do not show up for their scheduled appointment will be charged in full.

Liability Agreement

I have read and completed the above information to the best of my knowledge. I will not hold Natural Flow responsible for any condition, of which they were not informed, which may worsen over time through treatment.

Date

Signature of patient or legal guardian