Informed Consent

I, (print your name)_____

request care by the practitioners of Essential Natural Health. I have sought care of my own free will and hereby authorize the performance of diagnostic procedures and treatments described to me by Dr. Allen.

Dr. Micah Allen is a licensed Naturopathic Medical Doctor and Licensed Acupuncturist. She obtained her training from Bastyr University in Washington State.

Naturopathic Medicine utilizes natural therapies as mainstays for restoring one's health and natural balance. These include the use of vitamins and minerals, enzymes, amino acids, fatty acids, natural hormones, concentrated food preparations, botanicals, homeopathic medications, hydrotherapy, therapeutic exercises, dietary modifications, counseling, and other techniques which support the natural processes of the human body.

By law, Washington Department of Health wants you to know the **scope of practice** of a licensed acupuncturist (also known as East Asian medicine practitioner).

Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians; Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; Moxibustion; Acupressure; Cupping; Dermal friction technique; Infra-red; Sonopuncture; Laserpuncture; Point injection therapy (aquapuncture); and Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; Breathing, relaxation, and East Asian exercise techniques and Qi gong.

I understand that if I have been diagnosed by an oncologist as having any form of cancer, that by Washington State Law, I am required to also be under the care of a Medical Doctor. If you have cancer, I am available for adjunctive and supportive care only.

With this knowledge, I voluntarily consent to treatments by Dr. Allen and her staff. I realize that, as is the case with any medical treatment, no guarantees can or have been given to me by the doctor or staff regarding any cure for my conditions. I have been informed of potential risks or side effects involved in any of the diagnostic or treatment procedures. I have read and understand all of the above.

_____ _____

Signature of Patient or Person Authorized to Consent for Patient Date