Dakota
Natural Health Center

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INFORMED CONSENT FOR Direct to Patient Lab Testing

I hereby request and consent to the performance of lab testing and other procedures within the scope of the practice of naturopathic medicine on me (or on the patient named below, for whom I am legally responsible) by ***The Doctor of Naturopathic Medicine*** ("the doctor") and/or other doctors or naturopathic or Oriental medicine who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor, including those working at the clinic or office listed below or any other office of clinic, whether signatories to this form or not.

The lab tests require a blood draw or fingerprick. One of our trained doctors will collect the blood after the area is properly cleaned. After the blood is collected it will then be delivered to the lab for analysis. Results may take 10-14 days to be delivered back to us. Once received, our doctor will review and interpret your results and then deliver them to you via email along with interpretation of the results and supplement suggestions, if needed.

If you have any concerns regarding the testing results or supplement strategies; you are encouraged to establish as a patient or return to your primary care provider to discuss further. (Participating in this clinic does not substitute the new patient visit and if the client chooses to establish care at a later time, the new patient visit fee will still apply.)

Dakota Pharmacy and Dakota Natural Health Center cannot be held responsible for any outcomes related to supplementing for the testing listed above. If there are concerns or any medical conditions please discuss supplementation with your care provider prior to starting. This test is not intended to diagnose, treat, cure, or prevent any disease.

By signing this consent, you are agreeing with the above terms and conditions.

_____ _____

Patient/Guardian Printed Name Date

_____

Patient/Guardian Signature

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PLEASE PRINT

Today's Date:_____

Legal Name (first, middle initial, last):_____

Address: _____

City: _____State: _____ Zip Code:_____Birthdate:_____

Sex/Gender: M / F CELL phone #: _____Alternate#_____

Email address to send results to: _____

Can we email you? YES / NO

Emergency Contact:_____Phone:_____

How did you hear about us? __Facebook Website Friend Radio Other:_____

I have read/been given the HIPAA pamphlet **(please sign):**

_____

Pertinent Health History

Primary Reason for Today's Appointment: _____

_____

Has this problem been evaluated/diagnosed by a primary care provider? YES / NO

Please list ALL your medications/dosages AND supplements/vitamins:

_____
_____
_____
_____
_____

Do you have any of the following (check the box for YES):

____ History of blood clots, bleeding disorders or clotting disorders

____ Current or history of blood-born infection/disease

____ Surgically implanted devices, joint replacements, surgical "hardware"

____ Hypertension, diabetes, low blood sugar, easy fainting or bruising

____Diagnosed Thyroid Condition

Are you pregnant, trying to conceive or nursing/lactating? YES / NO

Are you taking blood thinning medications? YES / NO