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General Consent for Treatment

I, _____, hereby authorize all qualified medical personnel of Elevated Natural Health, LLC to perform routine and emergency medical exams and procedures as necessary to facilitate my and/or my child's diagnosis and treatment. I can request that students and preceptors not be included in my care or treatment at any time.

I also understand that I have a right to ask questions about and discuss to my satisfaction any exam or treatment that will be performed. I may request more information regarding: my diagnosis; the proposed care plan; any risks, complications, potential hazards, or side effects of a treatment or procedure; the likelihood of success; alternatives to the proposed treatment; and/or any other questions that may arise during or after the visit.

Notice to all pregnant women: All pregnant women must inform the provider if they have confirmed or suspected pregnancy as some of the therapies or exams could present a risk in pregnancy.

Notice to patients with implants: All patients with implants including, but not limited to: metal joint replacements, metal bone replacements, defibrillators, pacemakers, breast implants, muscle implants, and any other implant must inform the provider as some therapies or exams may present a risk for certain types of implanted materials.

Notice to patients with bleeding disorders: Please inform your provider of any family history or personal history of bleeding disorders of any sort (genetic, acquired, etc).

I also understand that providers at Elevated Natural Health may use alternative analysis and treatment modalities. I understand that Elevated Natural Health does not provide after-hours care at this time. While I am welcomed and encouraged to call at any time with any concern, I understand that a provider or staff member may not return my call for a minimum of 12-24 hours. Lastly, if I have a medical emergency, I understand that I should seek care with an emergency department immediately.

This consent will be in effect until revoked in writing by me.

I certify that I have read, understand, and agree to the above.

Patient's Printed name

Legal Guardian/Parent's Printed Name

Signature

Date

Please note there may be additional consent forms for you to review/ sign for specific treatments offered.