Every Season Health
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Cambridge, MA 02140
Phone: (617) 286-2612

Informed Consult For Health Consultation

I hereby authorize Dr. Elizabeth Orth to advise use of the following therapies:
Dietary recommendations: food and diet plans.
Nutritional supplementation: concentrated dosages of vitamins, minerals, and other substances naturally occurring in food.
Botanical medicine: concentrated or un-concentrated dosages of herbs, plants, and/or their constituents. Botanical substances may be prescribed as granules, teas, alcoholic tinctures, glycerite tinctures, capsules, tablets, creams, plasters or suppositories.
Homeopathic remedies: highly dilute quantities of plant, animal, and mineral substances delivered on sucrose pellets or in 25% alcohol liquid preparations.
Lifestyle recommendations and hygiene: changes in diet, exercise, sleep, and balancing of work and social activities.
Psychological: stress reduction techniques and lifestyle modifications.
I recognize the potential risks and benefits of these therapies as described below:
Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes.
I understand the U.S. Food and Drug Administration has not evaluated or approved nutritional or herbal supplements but homeopathic remedies are under the review of the FDA and have NDC#s. I understand that, as with drugs, nutritional/herbal supplements and homeopathic remedies may cause some side effects in certain sensitive individuals, may interact with certain prescription medications or lab tests, or cause symptoms due to certain pre-existing disease conditions.
I do not expect Dr. Elizabeth Orth to be able to anticipate and explain all risks and potential complications. I wish to rely on her to exercise judgment in recommending therapies she feels are in my best interest, based on the available knowledge. I have the opportunity to ask questions and discuss with Dr. Elizabeth Orth; 1) my condition 2) the nature, purpose, and potential benefit of the proposed therapies 3) the material risks inherent in the therapies 4) the probability of those risks occurring 5) the likelihood of success 6) reasonable available alternatives to the proposed therapies 7) the material risks inherent in such alternatives and the probability of such risks occurring 8) the possible consequences if advice is not followed and/or no therapies are undertaken.
Notice to Pregnant Women: All female patients must alert Dr. Elizabeth Orth if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.
With this knowledge, I voluntarily consent to the above therapies, realizing that no guarantees have been given to me by Dr. Elizabeth Orth or any of her personnel/students, regarding prevention, treatment, or cure of my condition or any condition. I understand that I am free to withdraw my consent and to discontinue participation in these therapies at any time. **I understand that it is not being recommended for me to discontinue any other treatment or care being provided by any other health care professional and it is my decision to change other treatments and inform the other practitioner of doing so.**
I understand Dr. Elizabeth Orth does not function as a primary care physician, and that she offers her services in addition to other services I receive. I understand she does not replace the services of my primary care physician or specialist (e.g. Oncologist, Cardiologist, Rheumatologist, OB-Gyn, etc). I will discuss all my prescription medication questions and changes with my primary care doctor and/or specialist. I understand that naturopathic therapies do not replace conventional medical advice/care.
I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. Exceptions to confidentiality are: danger to yourself; danger to another; or child abuse. The privileged nature of communication with Dr. Elizabeth Orth ceases under these circumstances. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that full disclosure of information has been made to me and all my questions have been answered to my full satisfaction.

____________________________________ ____________________

Patient's Signature Date

____________________________________ ____________________

Guardian/ Representative's Signature and Relationship Date