

Declaration and Consent to Treatment

I) This is to acknowledge that I have been informed and understand that:

- i) any treatment advise provided to me as a client of Robin Walsh, N.D. is not mutually exclusive from any treatment or advise that I may now be receiving or may in the future receive from another licensed health care provider
- ii) I am at liberty to seek or continue medical care from physicians or other health care providers who are qualified to practice in Ontario
- iii) Robin Walsh N.D. has not suggested to me to refrain from seeking or following the advice of another licensed health care practitioner

II) I declare that I have received a full and complete explanation of the treatment and or services that I will receive from Robin Walsh N.D. and hereby authorize and consent to treatment by her

III) I agree to pay the full account at the time of each visit or treatment

IV) I recognize that results are not guaranteed, and that even the gentlest of therapies potentially have complications in certain physiological conditions, in very young children or those on multiple medications. The slight health risks of Naturopathic treatments include, but are not limited to; aggravation of a preexisting symptom, allergic reactions to supplements or herbs, pain, fainting, bruising or injury from acupuncture needles.

V) I understand that a record will be kept of all of the health services provided to me. Dated this \_\_\_\_ day of \_\_\_\_\_, 20\_\_

Client's Name \_\_\_\_\_

Client's Signature \_\_\_\_\_

Robin Walsh N.D.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Diary for: \_\_\_\_\_

Date Started: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Liquids							
General Feeling/Specific Health Concern							