

## Informed Consent

### What You Can Expect From Me:

- I respect your time and therefore run on time for your appointments. However, there may be times beyond my control where patients require more attention.
- I will be clear about the costs and the reasons for or against the treatments, labs, procedures and supplements that are recommended

### My Expectations:

- **Please submit all of your intake & consent forms prior to your appointment date via email : [laura@laurapipher.com](mailto:laura@laurapipher.com) OR arrive 10-15 minutes before your scheduled initial appointment.**
  - This ensures the full visit time can be maximally utilized
- **Please arrive on time.** I am usually booked back to back so there won't be any extra time if you show up late
- As your appointment time is set aside for you, failure to show up for an appointment without 24-hours notice will result in a 50% appointment charge [note: there are of course exceptions to this]
- 24-hours notice is required to cancel appointments. This allows for other patients to book in your time slot
- Payment is due at the end of your visit. The clinic accepts cash, credit cards and debit for your convenience. The clinic can also direct bill to certain insurance companies.

### A note on email communication:

- Please allow a 24-hour (business day) response rate for all emails
- Email communications must be limited to clarify something already prescribed, or for you to provide further information upon request.
- **Treatment cannot be provided over email.** This includes a change in supplement or an opinion about a program/supplement offered elsewhere. Please book an appointment time for these matters

I acknowledge I have read and understood the contents of this form.

I hereby acknowledge that Dr. Laura Pipher, ND will explain to me the nature of the naturopathic treatment I am to receive and will include the benefits of the treatment, any risks associated with the treatment and any medical alternatives. I hereby consent to the treatments discussed during appointments and I understand that I may withdraw consent to these treatments at any time.

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

Patient Name (please print): \_\_\_\_\_

Parent/Guardian Name (please print): \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_