Art Mueller, N.D.

Statement of Acknowledgement and Consent to Treatment

By accepting this Naturopathic care you acknowledge:

1. That you understand that I am a Naturopathic Doctor, not a conventional medical doctor, that I use non-invasive and natural methods to assess, diagnose and treat bodily dysfunctions.

2. That any treatment you receive is not mutually exclusive from any treatment or advice that you now may be receiving or may receive in the future from another licensed health care professional.

3. That you understand the methods that I may use have proven clinical foundation, yet may not be accepted by standard (allopathic) medicine.

4. That you understand I am required by my licensing board to perform a physical examination on each new patient. This will be adhered to unless a full physical report is sent by the referring practitioner and that report is deemed acceptable.

5. That you understand that treatment and/or referral to other health practitioners is based on the assessment of your health revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation, including Chinese Pulses and Tongue. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

6. That you understand that I reserve the right to determine which cases fall outside my scope of practice, in which case the appropriate referral will be recommended.

7. That you are not the agent of any private or government agency attempting to gather information without so stating as your intentions.

8. That while changes in dietary habits are not an absolute prerequisite for treatment, that you understand that failure to follow sound nutritional, exercise and lifestyle programs could undermine the expected results.

9. That you are accepting or rejecting this care of your own free will.

10. That you understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this. I reserve the right to discontinue my services where it is apparent that your expectations and what I can provide are not in agreement.

11. That you understand that all fees for services and supplements are payable at the time of the appointment by the patient or their guardian. That there are fees applicable for completing insurance forms, writing letters and telephone conversations of more than 10 minutes.

Notice of appointment cancellation (preferably 24 hours) is required or an administration fee may be charged of $10.00. Any special financial arrangements must be made in advance.

I, _____ have read this form and accept the above statements.
PLEASE PRINT

Date: ____/____/____ Signature: _____
MM DD YYYY