

# GreenHouse

Naturopathic Medicine, LLC

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9 Ash Street

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(603) 249-6783

www.greenhousemedicine.com

## Consent to Treat

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

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*I understand that this is a Naturopathic Medical Clinic and give consent to this form of treatment. I understand that a naturopathic doctor is a physician who specializes in natural medicine. I am aware that with the guidance of the doctor, I may choose to be an active partner in helping determine my treatment plan, and I will ask the doctor to explain when there may be a treatment that I am unfamiliar with or do not understand. I am aware that any type of medicine, conventional or otherwise, may have potential for side effects. I will inform the doctor of any known allergies and provide previous medical history as necessary.*

Signed \_\_\_\_\_ Date \_\_\_\_\_

## Financial Agreement

I claim full financial responsibility for services rendered by GreenHouse Naturopathic Medicine and understand payment is required at the time of service.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date