Julia Greenspan, ND
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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*