Dr. Noelle King, ND

Phone: (971)279-2411 Fax: (833) 257-6059

Site: _____

Name: _____ Client#:_____ DOB: _____

I, _____, request and consent for the above named office to remove my intrauterine contraceptive (IUC).

I understand that there may be some discomfort, uterine bleeding, and or other problems associated with the removal of my IUC. I, thereby, acknowledge that I have received all information provided by and requested from the office regarding this procedure.

I further understand that if I am pregnant, early removal of the IUC reduces the risk of spontaneous miscarriage or preterm delivery.

I have been advised that I am guaranteed any additional answers to any and all inquiries regarding this procedure would I have a concern. I understand it is my responsibility to inform this office of any difficulties and return to this office for regularly scheduled visits as requested of me.

I release Dr. Noelle King, ND and /or the above office and its employees from any and all claims, damages or liabilities which I may have against them as a result of the receipt of medical services, supplies and / or procedures.

_____ _____

Client Signature Date

The above client signed the consent form in my presence after I counseled her and answered her questions.

Witnessed by:

_____ _____

Health Care Provider Signature Date

To be completed by Translator/Interpreter, if used:

I have provided an accurate translation of this information to the client whose signature appears above. She stated that she understands the information and was given the opportunity to have her questions answered.

_____ _____

Translator/Interpreter Signature Date