



## Dr. Noelle King, ND

Noelle King, ND

2540 NE MLK Jr Blvd Portland, OR 97212

### INFORMED CONSENT FOR TREATMENT

I, \_\_\_\_\_, voluntarily consent to be treated with Naturopathic medicine by Noelle King, ND. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I authorize Dr. King to use any of the following as necessary to give proper assessments, determine treatment approaches or otherwise address my health concerns:

**DIAGNOSTIC PROCEDURES:** Including but not limited to general physical exams, PAP smears and lab testing (including referrals for x-ray, MRI/CT, mammography, colonoscopy, endoscopy, or other imaging).

**THERAPEUTIC NUTRITION:** Including but not limited to dietary counseling, supplementation, and diet plans.

**IV THERAPY:** This includes but is not limited to, IM injections and IV infusions. Additional consent forms are necessary for patient to review prior to this therapy

**BOTANICAL MEDICINE/HOMEOPATHY:** Including but not limited to use of plants, minerals, vitamins, animal material and homeopathic medications prescribed as teas, tinctures (glycerite/alcohol), capsules, tablets, creams, poultices or suppositories.

**LIFESTYLE COUNSELING & EXERCISE PRESCRIPTION:** Including but not limited to promotion of wellness including recommendations for exercise, sleep, stress reduction.

**NATUROPATHIC MANIPULATION:** Including but not limited to specific manipulation of muscles, joints, or soft tissue using massage, neuro-muscular techniques, muscle energy stretching, visceral manipulation, and manual manipulation.

**BIRTH CONTROL INJECTION AND OR DEVICE IMPLANTATION:** This includes but is not limited to IUD placement and removal, hormonal injections for purpose of contraception etc

**PRESCRIPTION MEDICATION:** Including but not limited to prescribing pharmaceuticals or bio-identical hormones within the scope of naturopathic medicine.

**PELVIC FLOOR EVALUATION & TREATMENT:** pelvic floor assessment includes an internal vaginal exam to assess pelvic musculature health. Subsequent visits for treatment of findings may include internal vaginal massage, myofascial and/or trigger point release of the intervaginal musculature, instruction in pelvic muscle and breathing exercises, rectal assessment, and other techniques as needed. *Patients may experience adverse events as a result of treatment including physical effects (soreness or bleeding), as well as emotional responses.*

**POTENTIAL RISKS:** allergic reactions to prescribed medication (pharmaceutical, herbal or vitamin supplement), pain, discomfort, soreness, discoloration from topical applications, soft tissue or bone injury from physical manipulations and/or aggravations of pre-existing condition.

**NOTICE TO PREGNANT WOMEN:** Female patients must alert the doctor if they know or suspect that they are pregnant because some therapies pose a risk to pregnant women.

**By signing below, I consent to evaluation and/or treatment of my condition by Noelle King, ND. I have been advised of risks of treatment and I fully understand these risks. I understand the nature and the purpose of the procedures, evaluation, and course of my treatment. I**

realize that no guarantees have been given to me regarding cure or improvement of my condition.

I have been given the opportunity to ask questions, and my questions have been answered to my satisfaction. I certify that I have read, fully understand, and agree to the terms of this consent form.

Patient/agent signature:

Date:

If the patient is a minor: I, as the \_\_\_\_\_ parent or \_\_\_\_\_ guardian, authorize Noelle King, ND, to provide treatment to the patient.

Signature:

Noelle King, ND  
2540 NE MLK Jr Blvd Portland, OR 97212

#### FEES & FINANCIAL AGREEMENT

**PAYMENT INFORMATION:** Currently, **Regency BCBS, Providence, MODA ODS Plus, Cigna, Aetna, United, CHP, ASH, Health Net,** and **Pacific Source** insurance plans are accepted. Co-pay is due at time of service. ***Please check your coverage for Naturopathic Medicine prior to visit.***

**For OUT-OF-NETWORK plans payment is due at the time of service. Cash, check, debit and credit card (VISA or MasterCard) are accepted.** Out-of-network insurance plans will be billed and if payment is received, a check will be issued for the balance.

**Please note:** *it is ultimately your responsibility to determine coverage for Naturopathic care with your insurance carrier. I will verify insurance to the best of my ability prior to your appointment but cannot make guarantees of coverage.*

**CANCELLATION & NO SHOW POLICY:** Please cancel **24 hours** before your appointment time to avoid a **\$100 fee** for missed appointments. There are no exceptions to this policy. I reserve the right to bill you if cancellation is not made within 24 hours of your appointment.

Patient/agent signature:

Date:

If the patient is a MINOR: I, as the \_\_\_\_\_ parent or \_\_\_\_\_ guardian, authorize Noelle King, ND, LLC to provide treatment to the patient.

#### ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.**

I understand that Noelle King, ND may use and disclose my private health information, which may include written records or spoken words regarding health history, health status,

symptoms, examinations, test results, diagnoses, treatments, procedures, and similar types of health-related information, in the course of providing Naturopathic medical care and/or Holistic Pelvic Care™ to me or in the event of consultation with other third parties including health care providers.

If I request submission of my medical records to any third party (e.g health care providers, case managers, insurance representatives, lawyers), I understand I will need to provide a *signed release* prior to the transmission of medical records or any discussion between Noelle King, ND, and any third party about my treatment.

I, \_\_\_\_\_, hereby acknowledge that Noelle King, ND has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

**Noelle King, ND**  
**(971)327-8338**

I also understand that I am entitled to receive updates upon request if Noelle King, ND amends or changes its Notice of Privacy Practices in a material way.

**Signature:**

**Date:**

**Relationship to Patient, if signed by someone other than patient.**