Visceral Synergy & Advanced Immune Wellness

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INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the physician, Ron Mariotti, ND, to perform or refer for the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **Common Diagnostic procedures:** e.g., venipuncture, Pap smears, radiology, laboratory, X-ray.
- **Minor office procedures:** e.g., dressing a wound, ear cleansing.
- **Medicinal use of nutrition:** e.g., therapeutic nutrition, nutritional supplementation, and intramuscular vitamin & herbal injections.
- **Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's own innate healing responses.
- **Hydrotherapy:** e.g., constitutional hydrotherapy treatments with electrostimulation, contrast baths.
- **Physical medicine:** e.g., ultrasound, naturopathic adjustments, Craniosacral therapy, Visceral Manipulation.
- **Pharmaceutical medicine:** e.g., prescription of drugs listed on the Washington State naturopathic formulary.
- **Lifestyle counseling and hygiene:** e.g., diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
- **Psychological counseling**
- **Contraception**

I recognize the potential risks and benefits of these procedures as described below:

- **Potential risks:** allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.
- **Potential benefits:** restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
- **Notice to pregnant women:** All female patients must alert Dr. Mariotti if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy. I also understand that I must inform Dr. Mariotti if I have an IUD.

If I am receiving Visceral Manipulation I understand the following:

- **The function of my organs** are a direct reflection of their ability move freely and there is a connection between local visceral restrictions and distal effects due to lines of tension and fascial interconnections. I understand there is a connection between my brain (my central nervous system) and my dysfunctional / restricted organs.
- **I understand the general time frame of 36-48 hours** that is needed for my central nervous system to integrate the new information provided to my organs via Visceral Manipulation.
- **I also understand the possible outcomes after treatment** wherein symptoms can become worse for a few days before they improve, which is only a reflection of my body integrating this new information.
- **I also understand that no guarantees have been made by Dr. Mariotti** to the effectiveness of this treatment of Visceral Manipulation.

I recognize that if I withhold information, specifically requested by Dr. Mariotti I will be impeding his ability to provide me with the best possible care.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Ron Mariotti regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years, after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my physician to the best of his ability.

My signature confirms that I am informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that I may request a written definition of the RCW rules and how these rules define the way in which my private information is used or disclosed to carry out treatment, payment, or health care operations.

_____ _____

Date Signature of Patient

Original to Chart
Copy to Patient if requested