Julie Flynn, ND · Organic Health Institute · Gilbert, AZ 85297

Informed Consent

Consent for Treatment

I _____ consent to being treated by Dr. Julie Flynn at Organic Health Institute. I understand that Dr. Flynn is a board-certified Naturopathic physician, licensed by the State of Arizona Naturopathic Physicians Medical Board.

I consent to the services recommended and provided to me by Dr. Flynn and licensed professionals taking part in my health care.

Treatments and services may include but are not limited to the following (please initial by each service):

_____ Acupuncture
_____ Chinese herbs
_____ Botanical medicine
_____ Homeopathy
_____ Nutritional counseling
_____ Detox and restock program
_____ Shopping with the doc
_____ Weight loss program
_____ Supplements
_____ Prevention counseling
_____ Injections (vitamins)
_____ Facial rejuvenation
_____ Hydrotherapy
_____ All other treatments recommended by Dr. Flynn that may not be listed

I understand that Dr. Flynn is in service to provide the finest care so I can achieve optimal health and wellness, and that new treatments, therapies, and services may be added as time goes on, and as such, the above list is subject to change.

I understand that the states of Indiana and Kentucky do not recognize naturopathic physicians as primary care doctors, as KY and IN are not yet licensed for Naturopathic Medicine. Therefore, Dr. Flynn cannot prescribe medications and should not take the place of your primary care physician until state laws change.

Consent to payment and late fees:

I _____ understand that in an effort to best serve all patients; *24 hours notice is required when cancelling an appointment*. If an appointment is cancelled with less than 24 hours notice, *a $25 fee will be charged*.

In addition, I understand that Dr. Julie Flynn, does not accept insurance, and I am therefore responsible for payment in full upon any and all services rendered.

I have read the Informed Consent document in its entirety and understand the above consent of treatment, payment, late fess, and authorizations. In signing this document I am consenting to being treated and counseled for my medical condition(s) by Dr. Julie Flynn.

_____ _____

Patient Signature (if 18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date