



Beth Quintana, ND  
9728 Greenwood Av N  
Seattle, WA 98103  
206.602.7140

### INFORMED CONSENT FOR TREATMENT

I, \_\_\_\_\_, hereby authorize Dr. Elizabeth Quintana to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- Common diagnostic procedures:** e.g. venipuncture, Pap smears, laboratory.
- Minor office procedures:** e.g. cleaning, suturing, and dressing a wound, ear lavage, therapeutic injections including intradermal, subcutaneous, and intramuscular.
- Medicinal use of nutrition:** e.g. therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
- Botanical medicine:** e.g. botanical substances may be prescribed as teas, alcoholic or glycerin 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 healing responses.
- 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.
- Physical medicine:** e.g. craniosacral therapy, myofascial release, massage, hot and cold therapy, stretching, therapeutic exercise, naturopathic manipulation, visceral manipulation.
- Psychological Counseling:** e.g. short-term focused counseling.
- Biofeedback:** e.g. heart rate variability or thermal/peripheral temperature biofeedback.

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, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture, or procedures. Notify Dr Quintana if you experience any symptoms which may be secondary to the above procedures.

Potential benefits: restoration of health and the body’s maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, prevention of disease or its progression.

Notice to pregnant clients: All pregnant clients must alert the Dr Quintana if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr Elizabeth Quintana or any associated personnel 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 Dr Elizabeth Quintana to the best of her ability.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client Representative or Guardian

\_\_\_\_\_  
Printed Name of Client Representative