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Naturopathic Doctor Disclosure Statement and Consent for Treatment

Nature of the services provided:

- Preventative medicine
- Integrative medicine (meaning in cooperation with your M.D. or D.O.)
- Nutrition
- Homeopathy
- Herbal Medicine
- Body work
- Vitamins, minerals and other supplements.
- Physical exam, blood work, imaging and other diagnostic techniques.

Naturopathic Doctors may be registered in multiple states. I am registered in Colorado. Complaints regarding Naturopathic Doctors must be submitted in writing to the Office of Naturopathic Doctor Registration. To obtain a complaint form, please contact the Division at (303) 894-7414 or find more information on how to file a complaint at: http://www.dora.state.co.us/reg_investigations/file_complaint.htm.

Naturopathic Doctors are registered by the state to practice naturopathic medicine under the "Naturopathic Doctor Act." They are not permitted to perform the following acts:

- Prescribe, dispense, administer or inject any prescription medications or devices other than epinephrine for anaphylaxis and barrier contraceptives (not including IUDs).
- Perform surgical procedures, including surgical procedures using a laser device.
- Use general or spinal anesthetics, other than topical anesthetics.
- Administer ionizing radioactive substances for therapeutic purposes.
- Practice medicine, surgery, or any other form of healing other than Naturopathic Medicine.
- Practice obstetrics.
- Perform chiropractic services (spinal adjustments, manipulation, or mobilization). Physical medicine, as described in § 12-37.3-102(12)(b), C.R.S., is permitted.

- Recommend the discontinuation or counsel against a course of care, including a prescription drug that was recommended by another health care practitioner licensed in Colorado, unless the Naturopathic Doctor consults with the health care practitioner.

- REQUIRED FOR THE TREATMENT OF CHILDREN UNDER 8:

    1. this form must be fully completed and signed (both sides)

    2. the most recent immunizations schedule recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services is provided to the parent or guardian with this form; and

    3. a release of information form is provided to the parent or guardian requesting permission to exchange information with the child's licensed pediatric health care provider, if the child has one.

PAYMENT: Payment is due at the time of service by cash, check or credit card. Health savings account funds are accepted for all services. You may request a coded receipt to submit to your insurance company for possible full or partial reimbursement.

Signature of Patient (or Guardian) _____ Date:_____

Printed Name of Patient (or Guardian)_____

Disclosure Statement for the Treatment of Children Under 8 Years Old

1. I, Joshua Goldenberg, N.D. am a Naturopathic Doctor registered under Title 12, Article 37.3, of the Colorado Revised Statutes. Colorado Registration number 45.
2. I am not a medical doctor or a physician licensed under Title 12, Article 36, of the Colorado Revised Statutes.
3. I recommend that the patient named below have a relationship with a licensed physician, or if the patient is a child aged birth to seven, with a licensed pediatric health care provider.
4. If the patient is a child aged birth to seven, I recommend that that the child's parent or guardian follow the immunizations schedule that accompanies this form.
5. If the patient has a relationship with a licensed physician or pediatric health care provider, I will attempt to develop and maintain a collaborative relationship with the physician or pediatric health care provider. To permit this, the patient (or patient's parent/guardian if patient is a minor) will need to sign a separate release allowing me to exchange information with the licensed physician or pediatric health care provided; a medical release form.

_____ _____ (Joshua Goldenberg, ND)

Acknowledgement and Consent for Treatment (to be completed by the parent/guardian)

I, _____ (parent or guardian's name, printed), acknowledge receipt of the above disclosure statement and give my informed consent for the treatment of my child or dependent, _____ (print patient's name), who is under the age of 8, by Joshua Goldenberg, ND, a Colorado Registered Naturopathic Doctor.

Check one: The child ___ does ___ does not have a relationship with a licensed physician or pediatric health care provider. Name of licensed physician or pediatric health care provider:

_____

_____

Signature of Parent or Guardian_____ Date:_____

(This form must be completed and signed prior to the initial examination of the patient. If this form is altered, the form provided to the patient must contain all of the information detailed in this form, and comply with §§ 12-37.3-105(2)(f), (3)(b), and 12-37.3-111, C.R.S., and all other laws applicable to Naturopathic Doctors.)