WHOLEHEARTED HEALING, PC

8311 SE 13TH AVENUE, SUITE A

PORTLAND, OR. 97202

Hilary Farberow Stuart, N.D.

CONSENT FOR TREATMENT

Name:_____Date:_____

Age:_____ Birth Date:_____ Gender: M F

Are you: ____ Married ____ Divorced ____ Separated ____Widowed ____ Single ____ Partner

When and where did you receive your last health care:_____

_____

What was the reason:_____

Please list in order of importance the reason you are seeking treatment at this time:

1. _____
2. _____
3. _____
4. _____
5. _____

Notice of Policies for Wholehearted Healing, PC

1. I agree to have a primary care Physician.

I understand that, while inclusive of physical health, symptomology and diagnosis, the focus of this work will be delving into underlying issues and root cause etiology of current complaints. I understand that Dr. Hilary Farberow Stuart, while assisting and guiding me in working with these issues, is not my primary care physician, and will not be responsible for the diagnosis and treatment of any physical conditions I may have at this time or any time in the future. I agree to have my own separate primary care Physician at all times while in treatment with Dr. Hilary Farberow Stuart, and that my primary care Physician will be responsible for examination, testing

and treatment of all physical conditions. I agree that my primary care Physician and Dr. Hilary Farberow Stuart may confer at any time regarding my health care, and I give my permission for the sharing of information pertinent to my health care between them. I understand that Dr. Hilary Farberow Stuart may suggest diet, supplement, exercise and/or lifestyle changes as part of my health care. This treatment may be in conjunction with that prescribed by my primary care physician.

Name of Primary Care Physician_____

Address_____

Phone #_____

Email (if applicable)_____

2. I take responsibility for my health.

I give my permission to address the underlying issues and root cause etiology of my current condition with Dr. Hilary Farberow Stuart. In doing so, I agree that I am responsible for my health on the physical, energetic, emotional, mental, and spiritual levels. While Dr. Hilary Farberow Stuart can assist and guide me in the exploration, understanding and transformation of current concerns, it us ultimately my responsibility to bring those changes into my life. I am participating in this exploration of my own free will.

I certify that I am not currently abusing alcohol or drugs. I agree to inform Dr. Hilary Farberow Stuart if that should change in any way.

I certify that I am not currently suicidal, and do not have suicidal thoughts or ideations. I agree to inform Dr. Hilary Farberow Stuart if that should change in any way. I agree to seek professional psychological or psychiatric therapy and to obtain a primary professional psychiatrist or psychologist if any suicidal impulses arise. I understand that Dr. Hilary Farberow Stuart does not work with suicide in any way, and agree that she has no responsibility for my treatment in this regard should this arise in me at any time during our work together.

_____ _____

Signature Date

3. I consent to treatment with Dr. Hilary Farberow Stuart.

Dr. Hilary Farberow Stuart has explained her philosophy and approach to me. I understand that this is a holistic treatment that includes aspects of naturopathic philosophy, Energy Psychology, and my own spiritual connection. I understand that I am free at any time to ask questions, pursue

my own beliefs, say if something does not work for me, or terminate treatment. I agree to inform Dr. Hilary Farberow Stuart if I do not understand something, if I disagree with treatment or philosophy, or if in general treatment is not working for me.

I am participating of my own free will and take full responsibility at all times for my own well-being. I agree to participate with integrity for the purpose of self-understanding and transformation, for the highest good of myself and others.

Name (print)_____

Signature_____

Date_____

PLEASE NOTE: 24 hour cancellation before your appointment is required. Any cancellations after 24 hours will be charged full appointment price.

CLIENT BILL OF RIGHTS

As a client of an Oregon licensee, you have the following rights:

1. To expect that a licensee has met the minimal qualifications of training and experience required by state law.
2. To examine public records maintained by the Board and to have the Board confirm credentials of a licensee.
3. To obtain a copy of the Code of Ethics.
4. To report complaints to the Board.
5. To be informed of the cost of professional services before receiving services.
6. To be assured of privacy and confidentiality as defined by rule and law, including the following exceptions: reporting suspected child abuse, reporting imminent danger to client and others, reporting information required in court proceedings or by insurance companies or other relevant agencies, providing information concerning licensee case consultation or supervision and defending claims brought by client against licensee.
7. To be free from being the object of discrimination on the basis or race, religion, gender, or other unlawful category while receiving services.

You may contact the Board of Naturopathic Examiners at:
OBNE.Info@state.or.us
800 NE Oregon, Suite 407
Portland, OR 97232, 971-673-019