

**Dr. Kara H. Lolley, ND, LAc**  
**307 S. 12<sup>th</sup> Ave. Suite 20**  
**Yakima, WA 98902**  
**Phone: 509.759.7470 Fax: 509.759.7184**

## CONSENT FOR TREATMENT

**General Information:** Dr. Kara H. Lolley, ND, LAc is a licensed Naturopathic Physician and Acupuncturist. Due to the diversity of modalities Dr. Lolley offers, your treatment may include any or all of the following: Acupuncture and Oriental medicine, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling, and Nutritional Counseling.

To give proper assessments, determine treatment approaches, treat or otherwise address your health concerns she may perform diagnostic procedures including but not limited to venipuncture, pap smears, radiography, blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

- **Acupuncture:** Insertion of special sterilized needles at specific point on the body. Moxa, directly or indirectly burned on the skin, to stimulate acupuncture points.
- **Herbs/Natural Medicines:** Prescribing of various therapeutic substances including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (which may contain alcohol); topical crèmes, pastes, plasters, washes, suppositories or other forms.
- **Homeopathic remedies:** Highly dilute quantities of naturally occurring substances.
- **Dietary Advice and Therapeutic Nutrition:** Use of foods, diet plans or nutritional supplements for treatment – may include intramuscular vitamin injections.

**Potential Risks:** Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needles insertions, allergic reactions to prescribed herbs or supplements; and aggravation of pre-existing symptoms or latent conditions.

**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 the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Kara H. Lolley, ND, LAc or any of its personnel regarding cure or improvement of my condition. 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 my representative or me or otherwise permitted or required by law.

\_\_\_\_\_  
Guardian/Personal Representative's Name (PRINT)

\_\_\_\_\_  
Patient's Name (PRINT)

\_\_\_\_\_  
Guardian/Personal Representative's Signature

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Relationship/Representative's Authority

\_\_\_\_\_  
Date

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**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT**

I keep a record of the health care services I provide you. You may ask to see and copy that record. You may also ask to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so.

The **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient or Legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name if signed on behalf of the patient

\_\_\_\_\_  
Relationship  
(Parent, legal guardian, representative)