

# Foundations Natural Health - Melanie Trowbridge, ND, EAMP

---

10614 Beardslee Blvd., Suite D, Bothell, WA 98011

Phone: (425) 647-4249 Email: Melanie@FoundationsNatural.com

## Consent for Treatment

### **Naturopathic Medicine**

This disclosure is to advise you of the credentials of the practitioner, the scope of practice for Naturopathic Medicine in Washington State, and to document your consent for services.

**Credentials:** Melanie Trowbridge received a Doctorate in Naturopathic Medicine and a Master's Degree in Acupuncture from Bastyr University in Kenmore Washington in 2011. She passed the National Board Examination by the North American Board of Naturopathic Examiners and is designated a Naturopathic Physician in Washington State, holding license number NT 60252707.

**Scope of Practice:** I hereby authorize Melanie Trowbridge to perform the following treatments, which include but are not limited to: botanical medicines, nutrition and whole foods therapy and education, vitamins, minerals, prescription drugs, homeopathic medicine, physical medicine, hydrotherapy, health education, exercise instruction and demonstration, physical exams, diagnostic procedures and lab work, stress management, and lifestyle or naturopathic counseling.

I understand that while naturopathic physicians may offer primary-care in Washington State, they have some scope of practice restrictions, such as limitations in prescriptive authority and lack of hospital privileges. I acknowledge that in some situations, I may need to be referred to other appropriate providers or settings including hospitals, other primary providers, urgent care facilities, or specialists to obtain necessary or recommended medical care.

**I recognize the potential benefits and risks of these procedures, which include but are not limited to:**

- **Potential Benefits:** Restoration of health, relief of pain and symptoms of disease, Western and Eastern medical diagnosis, prevention of disease and disease progression.
- **Potential Risks:** Allergic or unforeseen reactions to herbal or pharmaceutical prescriptions, vitamins or supplements. Pain, discomfort, bleeding, bruising or deep tissue injury with diagnostic procedures. Potential aggravation of pre-existing symptoms. Pain or discomfort from physical therapies.

As with any medical care and treatment, I understand that there is no guarantee of complete resolution to any or all conditions that I may have. I acknowledge that compliance with treatment will improve the effectiveness of the recommended treatment protocol.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date