DONESE WORDEN, NMD
PHYSICIAN | RESEARCHER | GLOBAL EDUCATOR

Consent for Investigational Treatments

Dr. Worden owner of Repower Medical Clinic, LLC is a Naturopathic Physician licensed as a primary care doctor whose scope of practice includes prescriptive privileges and minor surgery. She uses western diagnostic methods including a thorough history, physical exam, labwork and imaging studies. Dr. Worden is also licensed in clinical nutrition, acupuncture, spinal manipulation, botanical medicine, counseling, homeopathy, therapeutic injection and other natural healing modalities. She uses her knowledge of both systems of medicine to integrate the best treatment for the individual patient for their physical and/or emotional ailments. The following treatments may be helpful for certain patients. If Dr. Worden decides that one of these treatments are appropriate she will fully explain the details about the treatment and get your verbal consent.

These therapies include such therapies as Platelet Rich Plasma, Apitherapy (Bee Venom), IV Therapy, Neural Therapy, Bio Puncture, Cold Laser Therapy, Homeopathic Injections, Trigger Point Injections, PRP, Prolotherapy, Fibroscan, Bio-Identical Hormones and Bioenergetic techniques that have been in used throughout the world and some have been documented as safe and effective in respected medical journals. Repower Medical Specialties conducts research in some of these areas. Additionally, the Arizona Board of Naturopathic Medical Examiners has given its approval to conduct some of these therapies.

I understand that I have been fully informed of the therapeutic protocols and possible side effects of the treatments. I understand that it is my prerogative to terminate participation in this program at any time and for any reason without prejudice.

I understand some of the therapies that I am requesting and agreeing to undergo are considered investigational and the data collected from my participation in this program may be used to further the understanding and treatment of the disease with those therapies. This includes, but is not limited to, publishing data, presenting paper in public or private journals, or sharing this information with other professionals. I understand data collected from my treatment, if presented, will be kept anonymous and that my confidentiality will be protected at all times.

I have been informed and understand that this protocol may or may not be recognized or approved by the FDA as a standard therapy. I therefore, hereby release Repower Medical Clinic and Dr. Donese Worden, staff or owners from any liability arriving out of the status of the approval or lack of approval of this therapeutic process.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

I HEREBY ACKNOWLEDGE AND UNDERSTAND THAT, BY SIGNING THIS VOLUNTARY CARE PATIENT CONSENT FORM, I AM GIVING INFORMED CONSENT TO THE PROVISION OF DIAGNOSIS, CARE, AND/OR TREATMENT BY DR. DONESE WORDEN AND CANNOT BRING A TORT OR OTHER SIMILAR ACTION, INCLUDING AN ACTION ON A MEDICAL, DENTAL, CHIROPRACTIC, OPTOMETRIC, OR OTHER HEALTH-RELATED CLAIM, AGAINST DR. DONESE WORDEN UNLESS THE ACTION OR OMISSION OF DR. DONESE WORDEN CONSTITUTES WILLFUL OR WANTON MISCONDUCT.

Patient Name (print):_____Date:_____

Patient/legal guardian Signature: _____