<u>Osteopathic Treatment</u>

GENERAL PATIENT INFORMATION

Name: ____ Gender: M/F

Date of Birth: ______________ (DD/MM/YY) Occupation: ________________________

Address: ____

City: ______________________ Province: _________ Postal Code: _________________

Telephone Home: _________________ Work: _________________ Cell: _________________

E-mail Address: ____________________________ @ ______________________. ______

Emergency Contact: _______________ Tel: _______________ Relation: ____________

Name of Medical Doctor: _____________________________ Tel: ___________________

Address: ____

Date of last appointment: __________________ Date of last physical: ________________

Medications? (Please list): ____

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Chief Complaint: ____

Other health problems: ____

____

Previous Surgeries/ Traumas/ Car Accidents?____________________________________

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Consent for Osteopathic Treatment

Name:____

Address:____

Home Phone:_________________________ Cell Phone: ____

Emergency Contact & Phone #: ____

I hereby agree with the fees and consent to osteopathic treatment (referred to as "Treatment"). Consent by the patient may be withdrawn at any time. I have not requested or received any express representation or warranties as to the Treatment.
All Osteopaths are registered members of NSAO (Nova Scotia Association of Osteopaths).
I understand that the receipt of Treatment (although rare) may involve risks. I do not suffer from any medical conditions that would put me at risk by receiving Treatment and I have not been instructed by a physician not to participate in Treatment.
I acknowledge that I have read this consent and I have discussed or have been offered the opportunity to discuss the nature of osteopathic treatment in general, specific treatment options and the contents of this consent.

RECORDS RELEASE AND SCHEDULING: Back to Health Chiropractic Inc, may disclose information from my records to doctors, hospitals or others for continuity of care and to any third party who requires information in order to fulfill an obligation benefiting me. I understand that payment for services is due in full at the time the service is rendered and that I may use cash, Visa, MasterCard or Debit. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, any amount authorized to be paid directly to this clinic by a third party will be credited directly to my account upon receipt. However, I understand that if I discontinue my care, any fees for services rendered to me will be immediately due and payable. All appointments during regular hours must be scheduled in advance**. Appointment cancellation requires 24 hours notice or there may be a $25.00 cancellation fee.**

COVID-19 CONSENT AND WAIVER: I am aware that Osteopathy involves techniques that will place me (or my child, if consenting on behalf of a minor child) in close physical contact with the Osteopath, making physical distancing impossible and leading to an increased risk of transmission of COVID-19. I have reviewed the safety information provided by Back to Health and agree to follow required procedures set out therein. ***I agree not to hold Monique Guilderson and Back to Health liable should I/my child contract COVID-19 as a result of attending or receiving treatment at Back to Health.***

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Signature of Patient/Decision Maker

I AM AT LEAST 18 YEARS OF AGE AND UNDERSTAND THAT MY CONSENT TO TREATMENT IS AT MY OWN RISK AND THAT BY SIGNING THIS LEGAL DOCUMENT, I AM WAIVING CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE.

_______________________		_______________________	
Witness Signature		Patient Signature	
Print Name	Date	Print Name	Date