Osteopathic Treatment

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): _____

_____

Chief Complaint: _____

Other health problems: _____

_____

Previous Surgeries/ Traumas/ Car Accidents?_____

_____

Informed Consent to Osteopathic Treatment

Name: _____
First Last

Address: _____
Street Address Postal Code

Home Phone: _____ Cell Phone: _____

Emergency Contact & Phone #: _____
Contact Name 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 Consent by the patient may be withdrawn at any time.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 consents 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.

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