INFORMED CONSENT

I understand that the therapist/practitioner is providing treatment within their scope of practice.

I hereby consent for my therapist/practitioner to treat me with the modality requested including assessments, examinations, and techniques which may be recommended by my therapist.

I acknowledge that the therapist/practitioner is not a physician and does not diagnose illness, disease, or any other physical or mental disorder. I clearly understand that the treatment requested is not a substitute for a medical examination. It is recommended I attend my personal physician for any ailments I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist/practitioner must be fully aware of my existing medical conditions. I have completed my Confidential Medical History form as provided by my therapist/practitioner and have disclosed all medical conditions affecting me. It is my responsibility to keep the therapist/practitioner updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist/practitioner to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third-party payers.

I have read the above noted consent and have had the opportunity to question the contents and my therapy.

By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist/practitioner.

I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name _____

Signature of Patient/Guardian _____

Date Signed _____