***Osteopathic Patient Consent Form***

Stefani De Marco B.H.K D.O.M.P

**Osteopathic Manual Practitioner**

Osteopathic treatments include manual therapies where the health practitioner places hands on your body. Many techniques involve contact between your body and practitioner’s body. Please initial/ check mark below the areas in which is acceptable for the practitioner to contact.

May include areas of Chest Wall \_\_\_\_\_\_\_\_

Pelvis & Pubic Bone \_\_\_\_\_\_\_\_\_

Intraoral (mouth only, gloves worn) \_\_\_\_\_\_\_\_\_\_

Glutes \_\_\_\_\_\_\_\_\_\_

I value the trust you have placed in me and I am taking all appropriate measures to safeguard your personal information and confidence. I request you provide your consent below.

I have informed the Osteopathic Manual Practitioner of all my physical and mental conditions as well as any medications and I will keep her updated on any changes.

I understand that the possible risks and benefits to Osteopathy will be explained to me regarding my individual treatment and accept responsibility to inform my therapist if I do not understand any aspects of the risks and benefits.

I understand Osteopathy is not a substitute for medical treatment and/or medications and that it is recommended that I work concurrently with my primary caregiver for any conditions I have.

I am aware that diagnosing conditions is not part of the Osteopathic scope of practice.

I am aware that the treatment is under voluntary consent and if I may, I can withdraw treatment at any time necessary.

I am aware and agree to the fee of the osteopathic session.

I am aware that all information I have provided to you is strictly confidential and will not be released without consent except where required by law.

I am aware of the **FULL** fee if I do not provide 24 hour notice for cancellations or to reschedule an appointment.

**I give my consent to release information about my treatments to mutual practitioners within the clinic if made necessary to benefit to my overall care & wellness. \_\_\_\_**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian (child under 18)

Insurance Information if you have Green Shield

1) GS # & Plan Members Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) GS 2 # & Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_