***Manual Osteopath Patient Consent Form***

 Fiona Dorey, DOMP, R. Kin, BHK-MS(Hons)

Osteopathy 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 below the areas in which is acceptable for the practitioner to contact.

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

 Pelvic Floor \_\_\_\_\_\_\_\_\_

Pubic Bone \_\_\_\_\_\_\_\_\_\_

 Jaw Area\_\_\_\_\_\_\_\_\_\_\_

 Gluteal area \_\_\_\_\_\_\_\_\_\_

Intraoral \_\_\_\_\_\_\_\_\_\_

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 Osteopathy Candidate 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 Osteopathy 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 Osteopathy Candidate 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 **cancellation/ no show 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 La Novus Wellness clinic if made necessary to benefit for my overall care and wellness. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please Print)

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent or Guardian (child under 18)

Insurance Information if you have Green Shield:

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

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