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?_____

_____

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 Consent by the patient may be withdrawn at any time.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.***

_____
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

Subscriber Enrollment

As an extension of the care you receive in our practice, may we add you as a subscriber to our website that will help you...

Get Well and Stay Well.

First name : _____ Last name : _____

Gender : ○ Male ○ Female

Date of birth : _____ / _____ / _____

Email address : _____

Naturally you can unsubscribe at any time.