CONSENT TO TREATMENT

In this document **"Impulse Health and Wellness"**, refers to its directors, officers, agents, representatives, employees, volunteers, independent contractors, subcontractors, successors and assignors.

CONSENT TO TREATMENT AND USE OF FACILITIES

There are risks and benefits involved with all types of therapies. Where appropriate my treatment may include manual therapy (involving treatment of the bones, joints, all soft tissue, nerves and nervous system, and organs of the body), modalities such as heat, ice, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, mechanical traction, acupuncture, intramuscular stimulation (IMS), and active exercise. The response to a specific treatment varies from person to person, and it may not always be possible to predict one's response to a certain therapeutic modality or procedure, or technique. We cannot guarantee precisely what one's reaction to treatment may be, nor can we guarantee that any treatment will help the condition one is seeking for assistance. There is also a risk that one's treatment may cause pain or injury, or may aggravate a previously existing condition. You have the right to ask your therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms, and personal goals. You may also discuss with your therapist what the potential risks and benefits of a specific treatment may be. Some potential risks may include:

- Health: strains; sprains; pain; overexertion; dehydration; fatigue.
- Premises: falls; collisions with objects, equipment or other people.
- Use of Equipment: mechanical failure of the equipment; negligent design or manufacture of the equipment; failure to use or operate the equipment correctly or within my own ability.
- My conduct and conduct of other persons: may increase the risk of damage, loss or personal injury.

You may decline any portion of your treatment at any time. It is important that you maintain an open and honest dialogue with your therapist, so he or she can adjust your treatment as needed.

By signing, I have read, understand, and agree with the information above. I understand there are risks associated with any treatment and that they may not be foreseeable. I understand that results are not guaranteed and that I may withdraw this consent at any time.

I choose to pursue treatment at **Impulse Health and Wellness** and waive any potential claim or liability against **Impulse Health and Wellness** that may result from my treatment, except in the case of gross negligence on the part of **Impulse Health and Wellness** and/or its staff and/or its professionals.

☐ **I consent for Impulse Health and Wellness to communicate with my family doctor.**

Please Print Name: _____ **Today's Date:** _____
YYYY/MM/DD

Signature of Patient: _____ **Client Date of Birth:** _____
(or Signature of Guardian if patient is underage)

IMPULSE
HEALTH AND WELLNESS

First Name: _____ Last Name: _____

Cell Phone: _____ Home / Work Phone: _____

E-mail: _____ BC Care Card #: _____

Date of Birth: Y: _____ M: _____ D: _____ Gender: Female | Male | _____

Address: _____

City: _____ Postal Code: _____

Emergency Contact: _____ Phone: _____

Physician (Full Name): _____ Phone: _____

How did you hear about Impulse Health and Wellness ?

_____ *(It really helps us out)*

Are you currently, or do you plan on, pursuing a claim with ICBC or WSBC for your injuries? If Yes please select below:

□ ICBC □ WSBC

ICBC / WSBC Claim #: _____ Date of Injury: _____

Adjuster / Case Manager Name: _____ Phone Number: _____

Have you had surgery for this injury? Yes / No If yes, Date of Surgery: _____

Have you had treatment for your injury prior to attending Impulse Health & Wellness Y / N

If yes then what have you had ? _____

___ Physiotherapy ___ Massage Therapy ___ Chiropractor ___ Naturopath Other _____

Please list any Medications you presently take: _____

Known Allergies (including medications, foods, oils and lotions, latex, etc.): _____

Late Cancellations & Missed Appointments:

In consideration of other clients and your therapist, please allow at least **24 HOURS NOTICE** to change or cancel an appointment. You will be charged the **FULL PRIVATE FEE** for late cancellations or missed appointment.
Thank you.

Signature of Patient: _____ Client Date of Birth: _____

(or Signature of Guardian if patient is underage)