Consent Form & Office Policies

In signing this form, you are fully aware and agree to all terms and conditions outlined in this document

1. I _____ acknowledge that Osteopathic Treatment does not substitute for medical diagnosis or examination. It is recommended that I see my primary care giver for that service.
2. All information recorded on the health history form is essential to giving you the most effective and safe treatment possible. In becoming a patient of this office, it is understood that everything discussed and or recorded is strictly confidential and no information may be released or discussed without your written consent.
3. As a new or returning patient, a full assessment is to be performed. New health history forms must be revised after a long duration away from treatment, when seeing a new therapist for the first time, and/or if your health status changes.
4. You are agreeing to disclose any changes to your health history as they occur.
5. If it is deemed that you are not safe to treat; the therapist will refer you to your physician for further examination.
6. **It is not the policy of this office to handle MVA or WSIB claims.**
7. Payment is due upon the completion of the treatment. A receipt will be issued to you following treatment. Please photocopy your receipt prior to sending it to your insurance provider in the case of loss in transit.
8. **Cheques returned NSF** will be subject to a service fee of **$25.00**. Letters for legal or medical purposes may be provided for a fee of **$300.00**
9. If you require a summary of treatments for the year, one may be provided for a fee of **$60.00**
10. **Missed appointments without 24 hours notice will be charged the full cost of the appointment, unless in the event of severe illness, family emergency or unavoidable circumstance.**
11. In the case of late arrivals, it is fully understood that ONLY THE TIME REMAINING for your scheduled treatment will be allotted.
12. Patients are not to consume alcohol or drugs prior to treatment. Patients under the influence of alcohol or ANY recreational drugs will not be tolerated and not be treated.
13. In signing this document, you are giving full consent to assessment and treatment on this date and for any treatments that may follow. You are aware that you are taking on full responsibility for any effects that may take place during or following treatment.
14. In signing this you also understand and agree that the therapist is not responsible for any slips, trips, falls or injuries that a person may have while within these premises.
15. I acknowledge that I have the right to withdraw consent in regard to treatment, treatment areas, and/or techniques used.
16. Patients under the age of 18 must have a parent or legal guardian accompanying them for the initial assessment/treatment and must co-sign this document. If a patient is under the age of 16, a parent or legal guardian must be present for all assessments and treatments that may follow.

Name: _____

Signature: _____

Signature of parent or guardian (if required): _____

Date: _____

Melissa Jeffreys M.OMSc • 905.746.9330 • melissa.osteopathy@gmail.com