INTEGRATIVE THERAPEUTICS

CONSENT TO TREATMENT FORM

I ______________________________, consent to Osteopathic treatment for the following complaint(s):

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My therapist has provided me with information relevant to treatment for the above complaints.

Alternative courses of treatment where applicable and relevant as well as the possible risks and side effects of my Therapist's proposed treatment plan, have been explained to me.

I have been informed that I may stop treatment at anytime.

Patient's signature: _______________________________________ Date: __________________

CANCELLATION POLICY

By signing this form the patient agrees to give 24 hours notice when canceling appointments. The patient also agrees that if 24 hours notice is not given they will be responsible for the entire treatment fee.

No receipts will be given for payment of missed appointments and subsequent appointments will not be scheduled until payment is received.

Patient's signature: _______________________________________ Date: __________________

Privacy Policy

Effective January 1 2004 the ***Personal Information and Electronic Documents Act (PIPED)*** requires businesses to control and protect the personal information that is collected form clients. Below we have explained who will see your information and why it is needed.

Treatment files information:

Name, address and phone number are collected to be able to contact you if there are appointment changes, payment inquires or news/changes pertaining to the clinic.

Permission to contact Doctor in the event that more details are needed pertaining to the condition being treated.

Health questionnaire is collected to be sure to avoid any contraindications for the treatment you receive. It also provides information about the areas that need to be treated, therefore allowing the therapist to create the most appropriate treatment plan.

I have read and understand that this information collected is private and only will be seen by the therapists treating me - Rob Hufgart, Carleh Little or Tara McEachern. It will be used only when necessary and in an appropriate manner.

Patient's signature: _______________________________________ Date: __________________