

CONSENT TO OSTEOPATHIC TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment; in particular you should note you may have

- slight pain or sourness, numbness, heaviness caused by treatment, which are necessary responses for the effect.
- dizziness or nausea feeling during treatment, especially when you are hungry or tired.
- skin bruise after treatment, which will clear away around one week.
- Soft tissue slight swelling or/and sourness in the next day of massage therapy.

I acknowledge I have discussed the following with my healthcare provider:

- the condition that the treatment is to address;
- the nature of the treatment;
- the risks and benefits of that treatment; and
- any alternatives to that treatment.

I understand that:

- I have option to receive my treatment either on cloth or off cloth. If off cloth, the secure draping will be applied, only the area to be treated will be uncovered.
- I have authority to stop the treatment at any time at any circumstance.
- I have had the opportunity to ask questions and receive answers regarding the treatment.
- A female adult assistant will be working together with the therapist to monitor the whole treatment session.

I consent to the osteopathic treatments offered to me by _____:

on the following area(s):

- | | | | |
|---------------------------------------|---|---|------------------------------|
| <input type="checkbox"/> head/neck | <input type="checkbox"/> face/mouth | <input type="checkbox"/> upper/mid/lower back | |
| <input type="checkbox"/> shoulder/arm | <input type="checkbox"/> elbow/wrist/hand | <input type="checkbox"/> stomach | <input type="checkbox"/> leg |
| <input type="checkbox"/> knees | <input type="checkbox"/> ankle/feet | <input type="checkbox"/> others _____ | |

I intend this consent to apply to all my present and future care with _____.

Patient signature _____
(or Legal Guardian):

Date: _____