**PHYSICAL MEDICINE**

**INFORMED CONSENT FOR TREATMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the practitioners of Dahlia Natural Health Clinic to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**Physical exam**: general, musculoskeletal, orthopedic and neurological exams and tests.

**Common diagnostic procedures**: e.g., venipuncture, Pap smears, laboratory.

**Soft tissue manipulation**: massage, neuro-muscular technique, muscle energy stretching, visceral manipulation.

**Osseous manipulation**: of the extremities and spine, traction, craniosacral therapy.

**Electrotherapies**: therapeutic ultrasound, low and high volt electrical muscle stimulation, diathermy, infrared, ultraviolet, transcutaneous electrical stimulation, microcurrent stimulation.

**Hydrotherapies**: hydrocolator, hyperthermia, contrast bath, cryotherapy.

**Diet and exercise prescription**: recommendations of food intake and stretching and exercise prescription.

**I recognize the potential risks and benefits of these procedures as described below:**

**Potential risks**: aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, change in bowel pattern, light headedness, injury from injections, venipuncture or procedures.

**Potential benefits**: restoration of health and the body’s maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

**Notice to Pregnant Women**: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Dahlia Natural Health Clinic or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

 I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

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Original to: Chart

Copy to: Patient (if requested)

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 Signature of Patient Representative or Guardian