Consent to Physiotherapy Treatment

I hereby consent to physiotherapy treatment which may include but is not limited to the following: manual therapy, exercise, education, electrical modalities, heat and cold therapy.
I have been told about the following:

- what the treatment is
- who will be providing the treatment
- the reasons why I should have the treatment
- the alternatives to having the treatment
- the important effects, risks, and side-effects of the treatment
- what would happen if I do not have the treatment

I understand the explanation and have no further questions. My consent is voluntary.

Date: _____Signature of Patient: _____
(or parent/guardian)

Date: _____Signature of Witness: _____

Consent for the Cost of Services

I understand that I am responsible to pay the fees for physiotherapy care I receive at each session. Fees are due at the end of your appointment once services are rendered. If treatment is billed as an insurance claim and your claim is denied, you will be responsible for payment for all services rendered.

MSK Assessment	$90.00
MSK Follow up	$65.00
Vestibular Assessment	$120.00
Vestibular/Specialty Follow Up	$90.00

There is a $40.00 fee for missing any appointment without notifying our office 24 hours prior to appointment time. Payment of this fee will be due at your next appointment.

Date: _____ Signature of Patient: _____
(or parent/guardian)
Date: _____Signature of Witness: _____

INFORMED CONSENT FOR ACUPUNCTURE CARE

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping and/or electro acupuncture by the above-named doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforations of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgement during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interest. I understand that the results are not guaranteed.

I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentions acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

READ BEFORE SIGNING

_____	_____	_____
Date Signed	Print Patient Name	Signature of Patient (or parent/guardian)