WHOLISTIC HEALTH CENTRE

CHIROPRACTIC
EXERCISE PHYSIOLOGY
MASSAGE THERAPY
WELLNESS CARE

Informed Consent to Care

Chiropractic care or/and Remedial massage therapy are both recognised as being an effective and safe method of care for many conditions. However, like all health care procedures, there are risks and potential complications that you should be informed about, before deciding to receive care from our team of professionals at Wholistic Health Centre.

All practitioners who manipulate the spine are required to warn patients of material risks associated with the procedures they apply. In exceedingly rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms. Other very slight risks include strains/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000) (Dvorak study in Principles and Practice of Chiropractic, Haldeman 2nd Ed.). Some patients with bone weakening diseases may require techniques to be modified to avoid the rare possibility of rib or spine fracture. It should be noted that (Vertebral artery and Provocation) tests for the neck are not 100% predictive but they are the best manual screening procedures currently available.

If you have any questions relating to the treatment procedures described to be used in your case or the possible alternative approaches to treatment such as soft tissue massage, joint mobilization, stretch/strength or exercise therapy, etc, please speak to your treating practitioner at Wholistic Health Centre. Please note that this consent does not waiver any Common Law Rights, rather it is merely for you to acknowledge that you have been informed and are aware of the most common potential risks and complications. Please note there may be a considerable degree of variation in individual patient response, and results are not guaranteed.

Please read the following carefully and discuss any questions you may have with your treating practitioner.

1. I have discussed with my treating practitioner the risks and/or potential complications associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition.

2. The following additional risks and/or potential complications as far as my proposed care is concerned have been explained to me (List if applicable) _____

3. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the treating practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the treating practitioner part should I fail to do so

3. I acknowledge that I am aware of and understand the nature of the proposed Chiropractic care or/and Remedial massage therapy and the risks and potential complications.

4. I understand that in some circumstances the expected result may not be achieved, even though the procedure is carried out with professional care and skill.

5. I understand that I can withdraw consent at any time.

6. I hereby consent to the performance of the proposed chiropractic care and remedial massage therapy by my therapist and/or any other intern/practitioners working in this practice.

Compensable Patients:
If you are obtaining Chiropractic care; Is the Chiropractic treatment you are requesting connected with injuries that may result in repatriation claims, third-party claims, worker's compensation claims, or any injuries for which you are intending to seek damages in court or other legal proceedings? No / Yes

If yes, please provide details: _____

I consent to receive appointment reminders (by SMS and email) and other information from time to time regarding the services of Wholistic Health Centre and that I can opt-out of these notifications if requested. This clinic has a **24-hour cancellation policy** that applies to all appointments. Failure to provide 24 hours notice when changing or cancelling appointment times and missed appointments will result in being charged the full appointment fee. It is expected that you will pay for each appointment at the end of your session.

Patient's Name(print):_____ **Patient's signature :_____**

(Parent or guardian to also sign if the patient is under 18)

Practitioners signature: _____ **Date: _____**