INFORMED CONSENT

To be completed by the patient

THE PURPOSE OF OSTEOPATHY IS TO RESTORE THE PATIENT'S HEALTH BY PROVIDING THEM WITH A NATURAL REMEDY THAT AIMS TO INCREASE THEIR BODY'S ABILITY TO HEAL ITSELF AND THEREFORE TO FUNCTION. THE TREATMENT'S SUCCESS DEPENDS ON THE PATIENT'S PHYSICAL AND EMOTIONAL STATE, THEIR EATING HABITS AND THEIR MEDICAL CONDITIONS.

By frequenting this Clinic, you grant us the permission to assess your health and, based upon this assessment, to treat you with the appropriate osteopathic techniques. The techniques employed are generally very beneficial and safe. The results are usually quick and longlasting. However, certain situations and conditions may have contraindications or complications. **It is your responsibility to provide us with all the necessary and relevant information regarding your health.**

You acknowledge that you may not ask an osteopath or incite them to perform a medical procedure (e.g. prescribing pharmaceutical drugs) nor to provide a diagnosis, since such procedures are, pursuant to the **Professional Code,** reserved to allopathic medical practitioners.

You confirm that you have presented yourself in your own name, in good faith and for no other reason than obtaining an osteopathic treatment.

Please discuss any concerns you may have with your osteopath prior to signing this document.

❏ **I CONFIRM THAT I HAVE READ AND UNDERSTOOD THIS DOCUMENT.**

____
PATIENT'S NAME

____
PATIENT'S SIGNATURE

TO BE COMPLETED BY THE RECEPTIONIST

For patients between 14 and 18 years old who are not accompanied by a parent

IDENTIFICATION ❏ ________________

To be photocopied and inserted in the patient's file

____
PARENT'S SIGNATURE FOR PATIENTS UNDER 14 YEARS OLD

____
DATE

____
EMAIL

____
TELEPHONE

How would you like to receive reminders for your future appointments?

❏ Text messaging ❏ Email ❏ Telephone

How did you hear about us?

❏ Friend or colleague ❏ Newspaper ❏ Brochure ❏ Internet ❏ Facebook ❏ Outdoor sign

❏ Other - Please specify: _______________________________________