Osteopathic Manual Practice, Ear Acupuncture/Seeds, Other Procedures and Treatments Consent to Treatment

I hereby request and consent to the performance of Osteopathic Manual Practice, ear acupuncture/seeds, cupping, infrared sauna, and other procedures and treatments offered at Wilson Wellness on me (or the patient name below for which I am legally responsible) by the below name.

I understand the methods or treatments may include but are not limited to osteopathic manual practice, ear acupuncture/seeds, microcurrent therapy, infrared sauna, and other treatments and procedures.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below agree to the above-named treatments and procedures. I also understand there's always a possibility of an unexpected complication. I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. _____(initials)

I understand that the practitioner is a DOMP and is not an MD physician and cannot provide healthcare normally receive from an MD. I also understand that if I have a serious problem or condition or I want someone to go over the details of my medical history from a medical doctor, neurologist, or orthopedic perspective, that I should see my family doctor/primary care physician and be referred to the appropriate doctor. I understand that this practitioner can provide complementary care and I realize that I must take responsibility for my own health. Furthermore, I understand that it is appropriate for me to consult with my primary care physician about the manipulative and or ear acupuncture treatment if I choose to do so, or if the practitioner recommends such a consultation. And I understand that I should inform the practitioner whether or not a licensed physician has examined me with regard to the issues.

I understand it may be necessary for my practitioner to contact another one of my healthcare providers in order to coordinate medical treatment, to discuss an emergency situation, and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____ (initials)

I agree to pay the full charge for any missed or forgotten appointments without 48-hour notice of cancellation. _____ (initials)

Wilson Wellness in Ontario can provide receipts that patient can submit to their insurance plan. Patients are responsible for full payment at the time of service. The patient is responsible for all fees above and beyond insurance coverage. _____ (initials)

_____
Patient's Name

_____
Patient's Signature

_____
Date Signed

Are you pregnant? ☐ Yes ☐ No

Helen Wilson
Name of DOMP

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

_____
Name of Patient

_____
Patient's Representative

_____
Relationship or Authority of Patient

_____
Witness

WILSON WELLNESS

Wilson Wellness (Inside Fine Herbs) • 2605 Howard Ave., #5 • Windsor, ON N8X 3W9
Voicemail and Texting: 226.782.3087 • admin@wilsonwellness.com