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 received 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 Michigan does not participate in nor accept any insurance; this includes Medicare. Patients are responsible for full payment at the time of service. _____ (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

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