Michelle Kormos Osteopathy Clinic

Please read & complete all 5 boxes.
Thank you.

Name: _____

Date of birth: (mm/dd/year) _____

mailing address & postal code :_____

_____

email:_____

home: _____ cell: _____ work:_____

1. Informed Consent: (PLEASE READ in FULL - do NOT sign until you speak with Michelle)

I consent and authorize Michelle Kormos to administer Manual Osteopathy treatments. I understand that Manual Osteopathy does not replace medical treatment and Michelle Kormos does not provide medical advice, or diagnosis. All information provided is for educational purposes and is not a substitute for advice received by your doctor. I also understand that there is no guarantee, warranty or assurance as to the results that may be attained.

I have been provided with information relevant to treatment and alternative courses of treatment have also been discussed if applicable. I understand the possible risks and side-effects of my therapist's proposed treatment plan, as they have been explained to me by the therapist.

I understand that I may stop the treatment at any time.

I assert that I have read and understand this entire informed consent.
If the patient is a minor (under age of 18) I give consent to have them treated.

Client Name (printed) _____ Date: _____

Client Signature (or Parent /Guardian: _____

Witness (Michelle Kormos) : _____

2. Cancellation Policy: (Please read in full and sign)

By signing this form I agree to the following cancellation policy:
A minimum 24 hours notice must be given when cancelling/rescheduling appointments. If less than 24 hours notice is given, the client will be responsible for the full treatment fee. No receipts will be given for the payments of missed appointments. Subsequent appointments will not be scheduled until payment is received.

Signature: _____ Date: _____

Witness: _____

3. Privacy Policy : (Please read in full and sign)

Effective January 1, 2004 the Personal Information and Electronic Documents Act (PIPED) requires businesses to control and protect personal information that is collected from clients. Below are explanations as to who will see your information and why it is needed

1. Name and Address, email and phone number are collected to be able to contact your if there are appointment changes, payment inquiries or news/changes pertaining to the clinic (if you so desire).
2. Permission to contact doctor in the event that more details are needed pertaining to the condition being treated.
3. Health History information is collected to be sure to avoid any contraindications for the treatment you receive. It also provides information about the areas that need to be treated, therefore allowing the therapist to create the most effective treatment plan.

Signature: _____ Date: _____

Witness: _____

4. Newsletter:

Would you like your email address to be added to receive the clinic newsletter? The newsletter goes about about 4 times a year with important clinic updates.

Please circle: YES NO

5. Weekly availability:

If there are treatment spots available I will send out an email the Thursday before alerting you to the availability. Would you like to receive this email?

Please circle: YES NO