The HEALING PATH Chiropractic & Wellness Centre

Kassem Tirani, BPT, Cert MDT
Physiotherapist

Informed Consent:

I understand the terms and conditions associated with my assessment and treatment at The Healing Path, under the care of the Physiotherapist. I do voluntary give my consent to the assessment and treatment from the Physiotherapist. I have received information about the proposed physiotherapy and rehabilitation services, alternative courses of action, the benefits, risks and side effects of the services and the consequences of not having the service proposed. I wish to rely on the Physiotherapist to exercise judgement during the course of the procedure that he/she feels at the time, based upon the facts he/she then knows, is my best interest. The Physiotherapist has responded to all my requests for other information about the services proposed. _____ *Initials*

Associated Risks:

I have been informed of the potential risks associated with physiotherapy treatment. They include, but are not limited to burns from modalities, redness, increase discomfort, re-injury, muscle sprains and strains and fractured bones. I understand that I may have increased soreness following treatment and will inform the therapist immediately of any concerns. _____ *Initials*

Consent to Release Information:

I give my consent for the employees of The Healing Path to obtain and/or release information from/to physicians, lawyers, family members, insurance companies, case managers, hospitals or health care practitioners as deemed necessary for my continuing care . _____ *Initials*

Payment Responsibilities:

I understand that I am responsible for all fees incurred at The Healing Path associated with my treatment program and agree to pay any and all outstanding balances on my accounts. _____ *Initials*

Patient Name_____

Signature of Patient or Guardian_____ Date_____

Signature of Witness _____ Date_____