ARC PHYSIO HEALTH

2520 Eglinton Avenue West, Unit 5-6, Mississauga, L5M 0Y4
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Chiropractic Consent Form

Dear Patient:

Chiropractic Care involves many different types of physical evaluation and treatment. As with all forms of medical treatment, there are benefits and risk involved in chiropractic. The physical response to treatment varies and cannot always be predicted as every individual is different. There is no guarantee that the treatment will help the condition you are seeking treatment for and there is a risk that treatment will cause some discomfort or aggravation of the existing condition.

During your chiropractic visit, it is often necessary to expose and touch the area in need of treatment. Every effort is made to preserve modesty and keep you comfortable. Please communicate with your chiropractor if you have any concerns during the treatment.

The chiropractor will explain your chiropractic diagnosis and discuss treatment recommendations with you. Chiropractic, as with any type of medical care, is most effective if you participate according to the treatment plan agreed upon. If at any time you have questions regarding treatment and services provided, please do not hesitate to talk to your chiropractor.

Arc Physio Health (Health Information Custodian for your records) is responsible for protection, collection, use and disclosure of your personal information according to privacy rules set by Personal Health Information Protection Act (PHIPA) and by Personal Information Protection and Electronic Documents Act PIPEDA).

☐ **By signing this, I hereby consent to the rendering of chiropractic evaluation and treatment as deemed appropriate by the treating chiropractor. I have the right to decline treatment at any time.**

☐ I authorize the release of all necessary information to my primary care provider and/or referring physician.

☐ I authorize the release of all necessary information to _____ in regards to my care and/or status. (Ex: family, legal representative, employer, guardian, other)

☐ I have read this form and agree to all the consent regarding chiropractic evaluation and treatment.

☐ **I understand** that the service fees may not be covered or exceed my plan or claim benefits and I am financially responsible for the entire cost of any unpaid claims.

☐ **Cancellation Policy:** Each appointment is booked and that time is reserved for you. We require 24 hour notice to cancel your appointment.Any missed or cancelled appointments without the required 24 hour notice will be charged a **$25 cancellation fee**. This fee is not covered by your extended health provider and you will be responsible for covering the cost. **Initial required** _____

_____ _____ _____

Patient/Guardian (Please Print) Signature Date