Osteopathic Informed Consent

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

We would like to take this opportunity to welcome you to Lakeside Natural Health Centre. This clinic utilizes the principles and practices of Osteopathy a natural medicine which aims to restore the function in the body by treating the causes of pain and imbalance. To achieve this goal the Osteopathic Manual Practitioner relies on the quality and finesse of their palpation and works with the position, mobility and quality of the tissues.

The treatment and advice provided to you by the Osteopathic Manual Practitioner is not being provided in place of, or to the exclusion of, any other treatment or advice that you may now be receiving, or may in the future receive, from a physician, surgeon, or any other licensed health practitioner. It is your responsibility to inform your practitioner of any pre-existing medical conditions, injuries or disease of which you are currently aware of. Your proposed treatment is based on Osteopathic manual practice and may contain some or all of the following: gentle mobilization of the joints, muscles, connective tissue, fluids, viscera and nerve pathways. It combines different manual techniques based on the principles of Osteopathic diagnosis and treatment, including advice on posture and exercise within the Osteopathic scope. It is your right and responsibility to inform the practitioner of your condition during the course of your treatment. The Osteopathic Manual Practitioners reserves the right to discontinue services where it is apparent that your expectations and the type of services provided are not compatible.

Privacy of your personal information is an important part of providing you with quality Osteopathic care. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. Our privacy protocol complies with privacy legislation and standards set out by the Ontario Association of Osteopathic Manual Practitioners.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my Osteopathic Manual Practitioner may discuss my case with other healthcare providers. I understand that I may look at my medical records at any time and can request a copy of my file with a fee of $0.10 per page. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect Osteopathic Manual Practitioners to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Osteopathic care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient Name (Please print name): ____
Signature of Patient or Guardian: ____________________________________ Date: ____________________
Osteopath Name: _______________________________ Osteopath Signature: ________________________

The vision of Lakeside Natural Health Centre is to provide true integrative health care. Given our commitment to this best-patient practice, we will communicate with your other practitioners at our clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.
I welcome professional dialogue regarding my case between members of my health care team at Lakeside Natural Health Centre (please circle): Yes / No
Signature: _______________________________

7 Elmwood Avenue North, Mississauga, ON L5G 3J8
Tel: 905.274-4375 Fax: 905-274-6209 Email: info@lakesidehealthcentre.com

Osteopathic Intake Form

Please complete both sides the following form to provide us with the background information we require to ensure you receive comprehensive care.

Contact Information:

Patient Name ________________________________
Date of Birth M____________D________Y__________
Gender (circle) ____Male / Female_____ Age__________
Home # ________________________________
Address ________________________________
____
Email ________________________________

Occupation ________________________
Work # ________________________
Cell # ________________________
Emergency Contact ________________________
Emergency Contact # ________________________
Parent or Guardian Name
(If under 16 years) ________________________

YES / NO Can we send you our monthly newsletter and new event listings via email? Your email address will not be shared.

How did you hear about Lakeside Natural Health Centre? ____

Health Care Providers:

Medical Doctor ________________________________
Phone # ________________________________
Fax # ________________________________

Dentist ________________________________
Phone # ________________________________
Fax # ________________________________

Specialist ________________________________
Phone # ________________________________
Fax # ________________________________

Specialist ________________________________
Phone # ________________________________
Fax # ________________________________

Other Health Care Providers:

Type of Provider ________________________
Name ________________________
Phone # ________________________

Type of Provider ________________________
Name ________________________
Phone # ________________________

Billing Authorization:

Credit Card on File:

Client's Name: ____________________________ Name as it appears on the credit card: ______________________________
Type of credit card (please circle): MasterCard / Visa Card #: ____
Expiration Date (month/year): ____________________

Cancellation Policy:

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours' notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with our clinic policy.

I, ______________________________________, authorize Lakeside Natural Health Centre to process the above credit card as "Signature on File" for any balance due on my account past 30 days and for any appointments not cancelled in accordance with Lakeside Natural Health Centre's cancellation policy. I understand that a receipt will be promptly sent to me upon any charges.

Patient / Cardholder's Signature: ____ Date: ___________________________