Alevia®
Health and Wellness Centre™

1251 Huron Street, Unit 111
London, Ontario N5Y 4V1
Tel 519.453.7117 • Fax 519.453.6540

Patient Number:_____

CONSENT TO HEALTH CARE SERVICES

1. I, _____ authorize Dr. Ghattas and his health professional associates to carry out the following procedure(s):

Chiropractic Care which may or may not include physical examination, active and passive joint manipulation, soft tissue mobilization and manipulation, interpretation and performance of diagnostic tests;
Physiotherapy which may or may not include therapeutic laser, photo therapy, electrical muscle stimulation, hot/cold therapy, acupuncture, joint manipulation/mobilizations, strength and conditioning of muscles, physical rehabilitation and home exercises;
Massage Therapy soft tissue manipulation to improve circulation, to decrease muscle tension and improve muscle length and tone.
Acupuncture and other procedures related to acupuncture including cupping and or electroacupuncture

There are some risks to the above mentioned treatments including but not limited to joint or muscle strains or sprains, superficial and or deep tissue bruising, possible fracture or dislocation, possible exacerbation or injury of disk, potential for stroke or vascular injury minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, and stuck or bent needles.

2. I do not expect the doctor/health professional to be able to anticipate and explain all possible risks and complications. I wish to rely on the health professional to exercise judgment during the course of the treatment, which the health professional feels at the time, based upon the facts then known, is in my best interest. I understand that the results are not guaranteed.

3. The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to my satisfaction by the above named doctor, therapist, associate, or assistants.

4. I also consent to the performances of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unknown conditions, that the above named doctor, therapist, associates, or assistants may consider necessary or advisable in the course of my health care.

5. I have read and understand the above consent form. I have also had an opportunity and asked questions about its content, and by signing below I agree to the above mentioned services and agree to hold Dr. Ghattas and his associates free and harmless from any claims demands and suits for damages from any injuries and complications that may result from such treatment.

_____ _____
(Patient Signature) (Date)

_____ _____
(Doctor/Health Professional) (Date)