INFORMED CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment. Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, muscle stiffness and spasm. It can also increase mobility and function, and reduce/eliminate the need for drugs or surgery.

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment. The risks include:

● Temporary worsening of symptoms or Sprain/strain – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

● Skin irritation or burn – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

● Rib fracture – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

● Injury or aggravation of a disc – Chiropractic treatment should not damage a disc that is not already damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the condition. The consequences of disc injury or aggravating a pre-existing condition will vary. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness or impaired function of extremities, and impaired bowel or bladder function.

● Stroke –Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives to chiropractic treatment may include consulting other health professionals (Physiotherapist, family doctor). Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns you are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____ _____ Date: _____ 20____.

Name (Please Print) Signature of patient (or legal guardian)

_____ Date: _____ 20____.

Chiropractor Signature

Massage Therapy Niagara

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby agree and consent to the performance of acupuncture. Acupuncture is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments.

Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment. I have been informed that in all acupuncture treatments only sterile, disposable needles are used to ensure the safest acupuncture treatment possible.

I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after acupuncture treatment. I will immediately notify the practitioner if I experience any symptoms or problems.

I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed. I am relying on the practitioner to exercise judgment during the course of my treatment, trusting that this treatment plan is appropriate and in my best interests.

At any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan. I state that I do not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anticoagulants.

By voluntarily signing below I hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

_____ _____ Date: _____ 20____.

Name (Please Print) Signature of patient (or legal guardian)

_____ Date: _____ 20____.

Chiropractor Signature

WELCOME TO MASSAGE THERAPY NIAGARA

New Patient Intake Form

* Please complete the forms before your first appointment. To ensure optimal care please complete the forms as accurately and detailed as possible. **All Information is Confidential.**

Patient Information	Date: DD/MM/YYYY
First Name:	Last Name:
Birth Date: DD/MM/YYYY	Age: Gender:

Contact Information		
Address:	City and Prov:	Postal Code:
Contact Phone #:		
E-Mail Address:		
Occupation:	Employer:	
Emergency Contact:	Contact Number:	

How Did You Hear About Us? (Internet, Social Media, Advertisement, Friend, etc.) Please list below:

_____

Physician Contact	Do we have your permission to send updates and reports to your family doctor? ☐ Yes ☐ No
Primary Physician:	
Address:	
Phone:	

Guardian (Please complete if under 16 years of age)			
Name:			Relationship to Patient:
Age:	Contact Number:	E-Mail:	
Address:	City and Prov:		Postal Code:
Consent to initial physical and history examination (please circle):		YES	NO
Guardian Signature:			

Patient Medical History

Age:	Height:	Weight:
Alcohol Use: YES NO	If YES, how frequent?	
Quantity of drinks per sitting?		
Smoking: YES NO	If YES, how many smokes per day?	

Current Medical Conditions (Diabetes, high/low blood pressure, depression, anemia, etc.):
Past Medical History & Surgeries (i.e. Fibromyalgia, Rheumatoid Arthritis, anemia, bone fractures, herniated discs etc.):

List Current Medications (Name and what its prescribed for):
Current Natural Supplements (Vitamins, Minerals, Herbs):
List Allergies:
Date of last Physical Exam:

General:							
Loss of Sleep		Night Sweats		Unanticipated Weight Loss		Changes in Bowel Bladder Movements	

Cardiovascular:							
Chest Pain		Shortness of Breath		Blood Pressure (High/Low)		Irregular Heartbeat	
Heart Problems		Lung Problems/ Congestion		Varicose Veins		Extremities Swelling	
Others:							

Females Only:							
Menstrual Irregularity		Menstrual Cramping		Vaginal Pain/Infections		Breast Pain/Lumps	
Date of Last Period:				Are You Pregnant? YES NO			
Males Only:	Sexual Dysfunction			Prostate Exam Date:			
Family History (Identify any past or present health conditions such as cancer, diabetes, high blood pressure, etc.):							

Musculoskeletal:									
Low Back Pain		Neck Pain		Mid Back Pain		Arm Pain		Leg Pain	
Joint Pain (Identify Joint):									

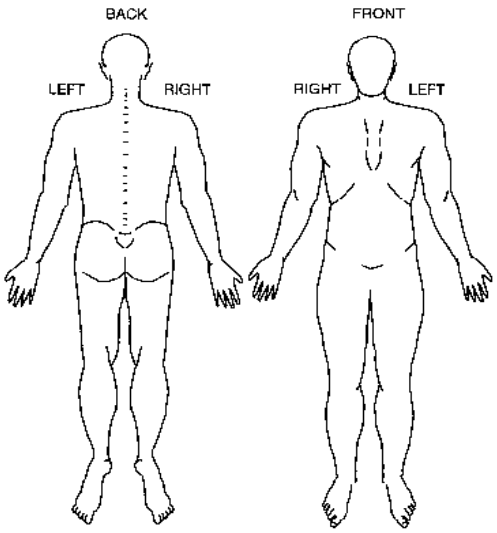
Headaches (if you have headaches please answer the following)			Date Headaches Started:					
Severity:	Mild		Moderate		Severe		Worst Headache Ever	
Frequency:	Monthly		Weekly		Daily		Intermittent	
Characteristics:	Pressure		Stabbing		Burning		Throbbing	
	Dull Ache		Tight Band		Others:			
Location (Identify where you feel the headaches):								
Nervous System:								
Numbness		Confusion		Forgetfulness		Dizziness		Fainting	
Convulsion		Paralysis/ Weakness		Decreased Sensation		Cold/Tingling Extremities			

Present Complaint (PLEASE FILL OUT) Is this an MVA case? ☐ Yes, or a WSIB case? ☐ Yes Claim #: _____

Reason for today's visit:
When did your symptoms begin (List date if possible)?
How did symptoms start? ☐ Suddenly ☐ Gradually over time
Do you remember doing something that started the symptoms? If yes, please describe:
Has your symptoms changed since it started? ☐ No Changes ☐ Improved ☐ Worsened

Have you had these symptoms before? YES NO If yes, describe:
What makes the symptoms worse?
What makes the symptoms better?
Are you taking medication for the symptoms? YES NO If yes, what medication and how often?:
When are symptoms the worst? ☐ Morning ☐ Afternoon ☐Evening ☐ Constant
Have you had imaging done (X-Ray, MRI, etc)? Location/Dates:
Do you have difficulty sleeping because of symptoms: YES NO If yes, how often?:
Any other comments or information the Chiropractor should know before seeing you?

Please mark the area of symptoms and indicate the type of symptoms: **A**= Ache, **B**= Burning, **N**= Numbness, **P**= Pins & Needles, **S**= Stabbing, **O**= Others



Please rate the following, 0 = No Pain 10 = Worst pain imaginable

What is your **average** pain level?

0	1	2	3	4	5	6	7	8	9	10

At **worst**, my symptoms are:

0	1	2	3	4	5	6	7	8	9	10

At **best,** my symptoms are:

0	1	2	3	4	5	6	7	8	9	10

Right **now**, my symptoms are:

0	1	2	3	4	5	6	7	8	9	10

CONSENT TO CHIROPRACTIC EXAMINATION

The risks associated with a chiropractic examination include, but are not limited to, short term aggravation of symptoms or muscle and ligament strains or sprains, and disc injuries. Although rare, rib fractures have been known to occur. The most common reactions to a chiropractic examination, if any, are muscle soreness and/or an increase in symptoms.

If you are not comfortable, you may stop examination at any time. Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition. I hereby consent to the chiropractic examination.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____20____.
Signature of Chiropractor

Direct Billing Policy

We offer direct billing to select insurance companies for your health care provided at Massage Therapy Niagara. This is not a mandatory service but a **courtesy to our clients**. We will try to directly bill only to those companies that may allow for it and for those policies that will pay the health care provider directly. If your insurance company/policy does not pay the provider directly then we will issue you a receipt on payment for you to submit to insurance yourself.

Direct Billing Consent, Authorization and Acknowledgement

Consent to Collect and Exchange Personal Information: I authorize my health care provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer/plan administrator and their service providers for the purposes of assessing my claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud/plan abuse. I confirm I have consent from the primary insured plan member (if not myself) to collect, use and disclose any personal information about them for the same reasons as stated above.

I hereby authorize my health care provider to directly bill my insurance company on my behalf for services provided at Massage Therapy Niagara. I acknowledge that if my claim is not paid in part or whole, or is not paid directly to the health care provider, that I will pay any balance owing immediately after treatment. In some cases my credit card information may need to be saved to my customer profile (PCI compliant) so that if the health care provider needs to wait on payment details, my credit card can be charged at a later time for any balance owing.

_____	_____	_____
Print name	Signature	Date

Privacy Policy

Your health care provider is responsible for all personal information entrusted in writing, as well as all information pertaining to the client. For example, health history and on-going treatment forms. All written and verbal client information is kept private and confidential and cannot be discussed or released unless written consent is given by the client for this release of personal information or as governed by law. Files are stored on location by the owner and can only be accessed by staff.

Cancellation Policy

To better serve our clients, and to avoid a charge, **24 hours' notice is required to change or cancel** existing appointments. If you cancel within 24 hrs or no-show, the following charges will apply:

- 50% of the service fee will be charged for an initial occurrence.
- 100% of the service fee will be charged for any additional occurrence.
- if you have a gift certificate, it will be used as payment.

Without this policy, such activity can negatively affect our availability to our client base. As a courtesy, we will try to email or text message you in advance of your appointment to remind you, if you have provided that contact information. However, we are not responsible if these automated reminders are unsuccessful.

I understand the above Policies and I agree they are fair and reasonable.

Signature:_____ Date:_____