CONSENT FORM

I, _____, give consent to the assessment and treatment by an osteopath employed at the Bedford Orthopaedic Health Centre. I understand the osteopath will discuss the clinical findings and inform me of the available treatment options. I will communicate to the osteopath any questions or concerns with respect to treatment and at any time I have the right to terminate treatment.

I, _____, give consent for Bedford Orthopaedic Health Center to communicate and send reports to my Family Practitioner, and referring health professional.

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24 HOUR CANCELLATION & MISSED APPOINTMENT POLICY

The Bedford Orthopaedic Health Centre asks all clients to **respect the 24-hour cancellation or missed appointment policy** as this time was set aside for you. With less than 24 hours notice, it is difficult for the clinic personnel to contact other patients who wish to be seen. Therefore, failure to comply, **50% of the treatment cost will be billed to you directly and not to your health insurance plan(s)**. This does not apply to situations of inclement weather when you feel it is unsafe to travel to your appointment or communicable illnesses.

In the event of **two (2) missed appointments**, without cancellation, patients will be **discharged** from Osteopathy services

I have reviewed and understood all information on both sides of this form.

Patient Name: _____

Patient's Signature: _____ Date _____

Witnessed: _____

Witness Signature: _____ Date: _____

HOW DID YOU CHOOSE US

Physician Recommendation

Internet/Google Search/SocialMedia

Family and Friends Recommendation

Location

Other_____