Natural Balance Integrative Health

Consent to Treatment

Any procedure provided at Natural Balance Integrative Health is intended to aid in wellness. The chiropractic, acupuncture, and massage therapy examination and treatment procedures are considered remarkably safe, but occasionally there can be risks. While the chances of experiencing any of these risks are extremely small, it is the practice of this office to fully inform and educate.

The potential complications of chiropractic, acupuncture, moxibustion, electrical stimulation, cupping, hot/cold therapy, and/or massage therapy include but are not limited to pain, swelling, bruising, skin discoloration, sensory changes, bleeding, bone fracture, dizziness, nausea, burns, and/or worsening of the condition. I understand that I can discuss the risks and benefits of any procedure with my practitioner before signing this form if I choose to do so, however, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her best judgment in my best interest during the course of treatment, based on the facts then known.

I fully understand that there is no implied or stated guarantee of success or effectiveness of any specific treatment. If you have any questions or concerns regarding your care or the after effects, please consult with your practitioner(s) at Natural Balance Integrative Health. With the above information and consideration**, I hereby give consent for myself, or my dependent to be examined and/or treated by the practitioners at Natural Balance Integrative Health. I understand that I am fully responsible for the payment of services rendered.**

Initial _____

Privacy Practices Acknowledgement

I understand that my personal health information will not be shared with any agencies or individuals without my written consent. For more details, a Notice of Privacy Practices is available, please ask your healthcare provider.

Initial _____

Cancellation Policy

I recognize that scheduling an appointment involves the reservation of time specifically for me, and consequently**, a minimum of 24 hours notice is required to reschedule or cancel an appointment**. The full service fee will be charged for sessions missed without such advance notice. I understand that insurance companies do not reimburse for missed appointments, and that I will be solely responsible for covering this expense, whether or not I have health insurance benefits. As a courtesy, Natural Balance provides a reminder call 48 hours prior to my appointment, but the presence or absence of this call does not avoid the charge of the cancellation fee.

Initial _____

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In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare procedures received, incurred or carried out at this office.

Printed Name of Patient Birthdate

Signature of Patient/Consenting Adult Date