Informed Consent Form

This is NOT a waiver form. It is part of our "duty of care" to you that all physicians, physiotherapists and other allied health practitioners inform you of any material (pertinent) risks associated with professional treatment techniques.

Some therapy techniques such as therapeutic massage, joint manipulations (low amplitude, high velocity), traction or mobilisations (low amplitude, low velocity) may cause injury. A remote possibility of injury to structures such as but not limited to; nerves, bones, muscles, ligaments, discs or arteries exists. Electro-physical agents such as ultrasound or interferential therapy may cause minor burns and abnormal skin reactions. Acupuncture and the above listed techniques can occasionally cause temporary local swelling, bruising or transitory increases in the levels or distribution of pain or other symptoms. In very rare cases acupuncture has been reported as being associated with bodily infections or collapse of a lung (less than 1 in 70,000 to 1.27 million). Allergic skin reactions to massage oils, strapping tapes, acupuncture needles or topical applications are a possibility.

Exercise can be physically demanding and potentially dangerous. I acknowledge this and agree that I will disclose all medical conditions that may impact my ability to exercise, I will not use the facilities & services if I am not medically or emotionally fit to do so and that I will comply with all rules, notices displayed around the facilities and any reasonable request from Entire Health staff.

By signing this document I consent to assessment and treatment by the therapist. I have the right to decline treatment that the therapist offers me at any time. I have the right to a second opinion at any time. I consent to the collection and keeping of information relevant to my current condition and past health history. I give permission to the therapist to exchange information with my doctor and other medical specialists when necessary. I understand that this information will be confidential.

For parents/guardians of children undergoing treatment - I understand that as a parent/guardian I am expected to be present during treatment at all times if my child is under the age of 16. I understand that I can consent not to be present during treatment.

I have read this form, understand the information it contains and give my consent to treatment.

Signed

Parent/Guardian if under 16

Name

Witnessed

Date

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