Patient Informed Consent to Treatment

Milena Nikolic #3947/ Holly Chiropractic
2 Marsellus Dr #15, Barrie
705 728-9999

I _____consent to have Milena Nikolic PT, R.Ac perform the following treatment on me:

- Acupuncture
- Cupping

I acknowledge that Milena Nikolic PT, R.Ac has explained the following to me:

- the nature of the treatment [set out above]
- the expected benefits of the treatment [*the Practitioner may list them on the form*]
- the material risks of the treatment [*the Practitioner may list them on the form*]
- the material side effects of the treatment [*the Practitioner may list them on the form*]
- alternatives to having the treatment [*the Practitioner may list them on the form*]
- the likely consequences of not having the treatment [*the Practitioner may list them on the form*]

I acknowledge that my Traditional Chinese Medicine Practitioner or Acupuncturist cannot guarantee the results of the proposed treatment.

I acknowledge that I have informed my Traditional Chinese Medicine Practitioner or Acupuncturist about my relevant health history, including whether I have any allergies, metal implants, if I suffer from any type of major bleeding disorder, if I use a pacemaker, or if I have any infectious viruses or diseases.

I understand that I have the right to withdraw my consent to the treatment at any time.

I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered. I acknowledge that my Traditional Chinese Medicine Practitioner or Acupuncturist has explained the applicable fees to me.

I acknowledge that I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for the treatment or plan of treatment set out above.

Signature of Patient or Substitute Decision-Maker: _____Date: _____

Practitioner's Signature: _____ Date: _____

By signing this form, I acknowledge that I have reviewed the form with the patient (or substitute decision-maker) and have answered the patient's (or substitute decision-maker's) questions.