CONSENT TO TREATMENT

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby voluntarily consent to Bowen Therapy treatment by Marla Hasquet.

I realize that my Bowen Therapy will be kept confidential. I understand that a record will be kept of the health services provided to me. Records will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy.

I acknowledge that results are not guaranteed. I do not expect Bowen Therapy to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Bowen Therapy.

I intend this consent form to cover the entire course of Bowen Therapy treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue Bowen Therapy treatment at any time.

I expressly warrant and agree that this Consent to Treatment is intended to be as broad and all encompassing as permitted by law and that this intent, in entering into this consent, may not hereafter be modified, interpreted or construed. The intent in making this Consent as broad as permitted by law is a material part of this Consent, without which no agreement for Bowen Therapy would have been entered.

I am of lawful age and legally competent to sign this Consent. I fully and clearly understand all of the provisions and terms above.

AGREED & ACCEPTED:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date