

MAR VISTA INSTITUTE OF HEALTH

Dear Patient: This information is confidential. We need this information so that we can better care for you. Your answers will help us determine if treatment in our office can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and complete as possible while filling out patient paperwork.

PERSONAL

Patient's Name _____

Date _____

INFORMED CONSENT

The determination of an appropriate plan of medical management for orthopedic conditions may involve or include the utilization of muscle testing and/or exercise rehabilitation procedures. Should these procedures be deemed appropriate in your case, you will be examined by a doctor, or assistant to determine if you have any conditions that indicate you should not engage in muscle testing or rehabilitation exercises.

I understand that, as with any form of exercise, muscle tests and rehabilitation procedures carry with them a small inherent risk of injury, which includes but is not limited to minor strains of the specific muscles being used during testing or rehabilitation. Additionally, as is the case with most health care interventions, there is a certain (albeit rare) inherent risk of complication associated with physical examination, physiotherapeutic and spinal manipulation procedures. These complications include but are not limited to muscle strains, dislocations, skin irritation, costovertebral sprains, electrical shock, fractures, disc trauma, minor burns, and stroke. I understand my doctor will not be able to anticipate all potential complications, but elect to rely on his/her clinical expertise and judgment to determine reasonable courses of clinical action, based upon known facts, which are considered to be in my best interest. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and hereby consent to voluntarily participate in a physical examination, physiotherapeutic, manipulative, muscle testing/rehabilitation, and/or other medical management procedures as deemed appropriate by my doctor. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor of such and not participate in these forms of evaluation or treatment.

Should I decide to receive treatment, I understand that I will be ultimately responsible for any and all charges incurred at Mar Vista Institute of Health. After a charge is 30 days past due a finance charge of 1.5% per month and penalty fee may be added. If any of my checks bounce, I will be billed a service fee. I hereby authorize Mar Vista Institute of Health to disclose medical information pertaining to my case to medical/technical consultants deemed appropriate by my doctor and submit claims to my insurance carrier on my behalf. However, I understand that verification of my eligibility and benefits is not a guarantee of payment.

All supplements, supplies and durable medical equipment purchases are final. There are no exchanges or returns

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Patient/Guarantor's Signature _____ Date _____