Women's Balance Wholistic Health Services

- (780).919.6870

Statement of Consent

I consent to having treatments and procedures from this clinic. I understand that the professional treatment I receive is for the purpose of improving, restoring and/or maintaining my personal health. I further understand that the treatment should not be construed as a substitute for medical examination, diagnosis or treatment. I also understand that I can refuse treatment at any time.

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.

I wish to rely on my practitioner to exercise judgment during the course of treatment, which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be release without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Name: ____ Signature: ________________________________

(Print name of representative if represented by another) (Signature of Representative)

Date: ____