ALETRIS CENTER of INTEGRATIVE MEDICINE

Consent for Physical Manipulation

I__________________________________________do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulation/adjustments/taping involving the movement of the joints and soft tissues. Physical therapy and exercises may also be used.

I have had the opportunity to discuss the nature and purpose of naturopathic manipulation and other procedures with the doctor of other clinic personnel at Aletris Center of Integrative Medicine.

I understand and am informed that although naturopathic manipulation/spinal manipulation is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures. These risks include, but are not limited to: fractures, disc injuries, strokes, dislocations, sprains, bruising, soreness and physical therapy burns.

I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed by my doctor to be in my best interest.

I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. To properly treat my medical condition, ALETRIS must be contacted immediately if an adverse reaction or condition occurs. If an emergency medical condition arises or if I am unable to reach ALETRIS, I will seek treatment immediately from a trauma center or call 911. I understand that I am responsible for all costs associated with medical treatment obtained from ALETRIS or other physician, hospital or medical facility.

I have had the opportunity to discuss this document and any questions I may have regarding the nature and purpose of naturopathic treatments and procedures with an ALETRIS representative. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand that while I may ask questions regarding my treatment before signing this form and that I am free to discontinue participation in these treatments at any time. With this knowledge, I voluntarily consent to treatment using some or all of the above procedures, realizing that no guarantees have been given to me by physicians or representatives at ALETRIS. I understand that a record will be kept of the health services provided to me, and that this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

Signature ___________________________________ Date ________________

ALETRIS 7425 E Shea Boulevard, Suite 111, Scottsdale, AZ 85260
Tel (480) 998-2020 * Fax (480) 948-1367 * www.aletriscenter.com