



WELLNESS SPA

Patient Consent to Treatment

PLEASE READ EACH SECTION CAREFULLY. YOU MAY REQUEST A COPY OF THIS FORM FOR YOUR OWN RECORDS

I, the undersigned, do hereby request and consent to an evaluation and treatment by Chance to Change and its staff. I wish to rely on the Practice to exercise judgment for my best interest, the below-named patient, during the course of treatment. I will inform the Practice of any sensitive areas or adverse conditions that I may have had prior to, during or after treatment. I intend this consent to cover the entire course of treatment.

I understand that any questions I may have regarding the potential side effects, complications, treatment or treatment area may be directed to the attending Practice staff member during my evaluation and course of treatment.

I understand that the practice of medicine and surgery is not an exact science. I further understand and accept that fees are paid for performance of medical services only, and not a guaranteed result. I acknowledge by my signature below that although a good outcome is expected, and a reasonable effort has been made to establish realistic expectations, there cannot be any warranty, expressed or implied, as to the results that may be obtained.

I request and consent to be transported by Practice staff and/or emergency medical services to a hospital or emergency medical facility in the event of a medical emergency during the course of my treatment at the Practice.

Printed Patient Name

Date

Signature of Patient

Practice Representative Name

Signature of Practice Representative