INFORMED CONSENT FOR ASSESSMENT & TREATMENT

☐INTEGRATED FUNCTIONAL THERAPY ☐MEDICAL ACUPUNCTURE

I _____,understand that my assessment and treatment at Petra Health Collective is performed by Aris Georgilas and may include, but is not limited to:

Exercise prescription, manual therapy techniques (such as mobilizations, massage therapy, soft tissue release, myofascial release, osteopathic techniques and stretches) and therapeutic modalities such as heat, ice, therapeutic taping, and cupping). Other treatment options include electro-acupuncture/acupuncture/dry needling that involves the insertion of disposable and sterile needles through the skin into targeted tissue structures.

I understand that the primary goals of my treatments are to help reduce my dysfunction and pain, improve my mobility, strength, endurance, my overall functioning, and quality of life.

I understand that there are very small possibilities of risks or complications that may result from the above listed treatments. I do not expect the practitioner to anticipate all the possible risks and complications. I rely on my practitioner's judgment to make decisions based on my best interests.

Potential small but possible risk factors may include:

Manual Therapy & Myofascial release: Joint and/or muscle soreness and slight bruising
Exercise Therapy: Joint and/or muscle soreness
Therapeutic Taping & Cupping: Minor skin irritations such as redness or rash
Electro/Acupuncture/Dry Needling: Minor soreness, bleeding, bruising, nausea, fainting, headache, and infection, possible perforation of internal organs and stimulation of labour in pregnant women

I will immediately notify my therapist of any changes in my pregnancy or medical status.

I will have the opportunity to discuss with my practitioner, the nature and purpose of all my treatments and I accept the fact that there is no guarantee to the effectiveness of the treatment. I am aware that I may withdraw this consent and discontinue my treatment at any time.

I consent to the assessment and treatment offered to me by my practitioner. I also consent to the assessment and treatment of the following areas by the practitioner if clinically indicated: breast, chest wall, gluteal, and upper inner thigh.

I intend this consent to apply to all my present and future care at Petra Health Collective. I consent that the health records collected by Petra Health Collective will be available to all health providers involved in my circle of care. (For more information about your health records please ask to view our Privacy Policy).

_____ _____ _____

Patient/ Guardian name **Signature** **Date**