**Natural Balance Consent to Treat**

**Consent to Treatment** Any procedure provided at Natural Balance is intended to aid in wellness. The chiropractic, acupuncture, and massage therapy examination and treatment procedures are considered remarkably safe, but occasionally there can be risks. While the chances of experiencing any of these risks are extremely small, it is the practice of this office to fully inform and educate.

The potential complications of chiropractic, acupuncture, moxibustion, electrical stimulation, cupping, hot/cold therapy, and/or massage therapy include but are not limited to pain, swelling, bruising, skin discoloration, sensory changes, bleeding, bone fracture, dizziness, nausea, burns, and/or worsening of the condition. I understand that I can discuss the risks and benefits of any procedure with my practitioner before signing this form if I choose to do so, however, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her best judgment in my best interest during the course of treatment, based on the facts then known.

I fully understand that there is no implied or stated guarantee of success or effectiveness of any specific treatment. If you have any questions or concerns regarding your care or the after effects, please consult with your practitioner(s) at Natural Balance.

With the above information and consideration, I hereby give consent for myself, or my dependent to be examined and/or treated by the practitioners at Natural Balance Integrative Health. I understand that I am fully responsible for the payment of services rendered.

Initial \_\_\_\_\_

**Privacy Practices Acknowledgement** I understand that my personal health information will not be shared with any agencies or individuals without my written consent. For more details, a Notice of Privacy Practices is available, please ask your healthcare provider.

Initial \_\_\_\_\_

**Cancellation Policy** I recognize that scheduling an appointment involves the reservation of time specifically for me, and consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment**. A service fee equal to the price of the treatment scheduled will be charged for sessions missed without such advance notice, and applies to all visit types, including but not limited to chiropractic, acupuncture and massage therapy. By signing the below form, I understand that this charge will be taken automatically by our office, using the credit card reserved on file.**  I also understand that insurance companies do not reimburse for missed appointments, and that I will be solely responsible for covering this expense, whether or not I have health insurance benefits. **As a courtesy**, Natural Balance provides an email, text or phone reminder 48 hours prior to my appointment, but the presence or absence of this contact does not avoid the charge of the cancellation fee. **Please be aware that after three no call/no shows, you will no longer be able to schedule appointments in advance & will have to call the day of to check availability.**

By signing, I acknowledge and give Natural Balance permission to charge my stored card on file for any no show, or same day cancellations that may take place within the duration of my time as a patient.

Initial \_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare procedures received, incurred or carried out at this office.

Printed Name of Patient Birthdate

Signature of Patient/Consenting Adult Date