

CONSENT TO TREATMENT

The Ontario Government prefers patient to give consent to treatment in writing. By signing this Consent Form you acknowledge that you consent to treatment and have had your questions about treatment answered to your satisfaction.

Osteopathy, Physiotherapy, Massage, to name the few treatments we provide may include manual therapies where the health practitioner places his or her hands on your body such as your anterior chest wall, pelvis floor and pubic bones. Many techniques will involve contact between your body and the health practitioner's body.

Osteopathically, for internal treatments we may have to work in your mouth. A disposable vinyl glove will be worn. We might remove some of your clothing in order to facilitate treatment.

We, as a team are committed to provide an excellent quality of treatment and hospitality to our patients. If you do not feel comfortable with a given technique, please tell us immediately. The technique will be discontinued or modified to be comfortable for you.

Privacy Policy

On January 1, 2004 the Personal Information Protection and Electronic Documents Act (the Act) came into effect with a mandate to balance the privacy rights of the individual and the needs of commercial organizations to collect information for business purposes.

Osteopathic Health Centre remains committed to you, your health and respects your right to confidentiality. The privacy policy of Osteopathic Health Centre (OHC) is founded on the following principles:

Accountability

OHC is responsible for maintaining and protecting all information collected by the clinic.

Limited and Accurate Collection of Information

OHC limits the collection of personal information to that which is necessary for the provision of excellent health care. This information is accurately maintained in its most current form in order to fulfill the purposes for which it was collected.

Consent

A decision to receive care at OHC implies consent for the sharing of information internally, for purposes related to your health care only. Written consent is required from you in order to share your health care information externally. You may withdraw this consent in writing at any time.

Disclosure and Retention

Patient information is kept in a secure manner for a period of 10 years. This information will only be utilized for the purposes for which it was collected or if required by law.

Information Storage

Appropriate security measures are utilized to secure the privacy of all information collected in the delivery of your health care services.

Patient Access

You are entitled to view the information collected by OA regarding yourself. You may obtain a copy of your records. There is a fee for this service.

By signing this form, I _____ hereby give consent to your therapist for treatment and also to the collection, use, maintenance and disclosure of my personal information as indicated above, unless and until I advise otherwise in writing.

Signature: _____