Osteopathic Manual Practice, NADA: Ear Acupuncture/Seeds - Consent to Treatment and Cancellation Policy

Consent to Treatment

I hereby request and consent to assessment and treatment at Wilson Wellness by its practitioners, including but not limited to Osteopathic Manual Practice, Lymphatic Drainage, Cranial Sacral Therapy, NADA: Ear Acupuncture/Seeds, Cupping, Infrared Sauna, Microcurrent Therapy, and other complementary therapies offered by the clinic.

I understand the methods of treatment proposed may include, but are not limited to Osteopathic Manual Practice, Lymphatic Drainage, Cranial Sacral Therapy, NADA: Ear Acupuncture/Seeds, Microcurrent Therapy, Infrared Sauna, and Adjunctive Therapies. I understand that the specific treatments provided will be based on my individual needs and the practitioner's assessment.

I have been informed that I have the right to refuse any form of treatment. I have read, or have had read to me, this consent and understand that I have the right to ask questions, request modifications, or refuse any Treatment at any time without affecting my future care.

I understand that there are potential risks associated with treatments and that no guarantees of results have been made. This consent applies to current and future visits unless withdrawn in writing.

Scope of Practice

I understand that practitioners at Wilson Wellness (including DOMPs and complementary providers) are not Medical Doctors and do not diagnose medical conditions, prescribe medications, or provide physician-level services.

I understand that this care is complementary and does not replace medical care. I am responsible for consulting a licensed physician for diagnosis or medical concerns and agree to inform my practitioner of any relevant health conditions or changes.

Coordination of Care

I authorize Wilson Wellness to communicate with other healthcare providers when necessary for coordination of care or in the event of an emergency, in accordance with applicable privacy laws.

Communication & SMS Consent

I consent to receive appointment reminders, scheduling updates, clinic notifications, and occasional promotional messages via SMS and email.

I understand:

- **Message frequency may vary**
- **Message and data rates may apply**
- **I can opt out at any time by replying STOP**
- **I can reply HELP or contact the clinic for assistance**

I understand that consent to SMS communication is not required for treatment and may be withdrawn at any time.

Signature: _____ **Date:** _____

Appointment Responsibility & SMS Notice

Patients are responsible for keeping track of their appointment times. SMS reminders may be sent as a courtesy but are not guaranteed. The cancellation policy still applies whether or not a reminder is received.

☐ I understand and agree with the above.

Cancellation Policy

Your appointment time is reserved for you. Late cancellations and missed appointments impact on our practitioners and other patients.

New Patient Appointments

• $25 non-refundable deposit required (applied to first visit)

• 4 business days' notice required for changes or cancellations

Routine Appointments

• 2 business days' notice required

• Business days: Monday–Friday

Fees

• Proper notice: No charge

• Late cancellation: 100% of appointment fee charged

• No-show: 100% of appointment fee charged

How to Cancel

• Text or phone/voicemail (text preferred)

• Email cancellations are not accepted

Acknowledgement & Consent

☐ I have read and understand this information

☐ I have had the opportunity to ask questions

☐ I voluntarily consent to assessment and treatment

Patient Name: _____

Signature: _____ Date: _____

(If applicable)

Representative Name: _____

Relationship: _____

Signature: _____