JULIA KINSEY
OSTEOPATHY

Patient Consent Form

In certain circumstances, further investigations may be suggested which could include an x-ray or blood test. This will allow a full diagnosis of the problem to be made and will enable the osteopath to tailor a treatment plan to your needs. If further medical treatment is needed the osteopath may contact your doctor, with your permission.

I hereby consent to – Julia Kinsey - to contact my general practitioner, either verbally or in writing, which may involve releasing details of medical information, notes held and/or treatment received at the practice.

GP's name.....

Surgery .....

Covid 19 Screening

1. Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? Yes / No
2. Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, difficulty breathing, loss of taste or smell)? Yes / No
3. I consent that my contact details may be passed to NHS TEST and TRACE in the event that the osteopath contracts Covid-19 within 14 days of my last consultation

Statement of Consent for adult patients

I confirm that I have read the above information; I confirm that I have had the opportunity to discuss any concerns with the osteopath and have understood what has been explained to me. I consent to receive osteopathic treatment on this occasion, but I understand that I can refuse treatment (or any part of treatment) now or in the future without jeopardising future treatment at this practice. I understand that it is important that I inform my osteopath of any concerns, reactions or discomfort associated with treatment.

Signature .....

Print name in full ..... Date .....

Statement of Consent for patients aged 16 years or younger

I confirm that I have read and understood the above information, and I consent, as parent, guardian or appointed carer to this patient receiving osteopathic treatment at this time. I understand that they can refuse treatment (or any part of treatment) at any time in the future without jeopardising future treatment at this practice.

Signature .....

Print name in full ..... Date .....