Barbara Newlon, D.O.
818 5th Avenue, Suite 202
San Rafael, CA 94901
415-459-2522
Fax: 415-454-1456

# INFORMED CONSENT TO OSTEOPATHIC MANIPULATIVE TREATMENT AND CARE

**Print Patient's Name** _____

I hereby request and consent to the performance of procedures which are within the scope of practice of osteopathic medicine including, but not limited to, osteopathic treatments on me (or on the patient named above, for whom I am legally responsible) by the osteopath named above. Dr. Newlon utilizes a technique called myofascial release and the cranial concept in osteopathy. The technique is direct, but not harsh or invasive.

I have had an opportunity to discuss with the osteopath named above and/or with other office or clinic personnel the nature and purpose of osteopathy. I understand that the results are not guaranteed.

I understand and am informed that in the practice of osteopathy there are some risks to treatment, including, but not limited to, temporary 3-10 day soreness in the musculo-skeletal system after treatment, including areas of initial non-complaint. Other reactions can be temporary fatigue or a sense of "spaceyness" or light-headedness after treatment. Sometimes a temporary headache occurs. In babies and small children, a temporary increase in fussiness or agitation can occur for up to five days after treatment (this is rare). There can be transient (30-60 second) soreness in the area being addressed during treatment.

I do not expect the osteopath to be able to anticipate and explain all risks and complications, and I wish to rely on the osteopath to exercise judgment during the course of the procedure which the osteopath feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____
Signature of patient or patient's representative Print Name fo Patient's Representative

_____ _____
Witness to Patient's Signature Date Relationship or Authority of Representative