



INFORMED CONSENT FORM

WHAT SHOULD YOU EXPECT TO HAPPEN ON YOUR FIRST VISIT?

Our practitioners should make you feel at ease during your first consultation and any subsequent appointments. They must tell you what is happening throughout your session.

- You should feel free to ask questions at any point during the consultation and you can refuse/request a specific technique (i.e., structural/soft osteopathy).
- It is quite acceptable to bring a friend or relative along to the consultation if you prefer to do so. An adult or appointed representative should desirably be present with a patient who is 16 years or younger.

WHAT IS OSTEOPATHY?

Osteopathy is an established system of diagnosis and hands on treatment in which a caring approach to the patient and attention to individual needs are of primary importance.

It is a means of detecting and treating parts of the body including those affecting the neuro-musculoskeletal systems.

ON YOUR FIRST VISIT, AND BEFORE EXAMINATION BEGINS:

- The practitioner will discuss and record your current and past medical history in detail.
- It is essential that you inform him about any health condition or medication that is not discussed during the case history taking process e.g., if you experience fits, have a pacemaker or other electrical implants fitted, if you suffer unaccountable double vision, vomiting or dizziness or have difficulty swallowing.
- Equally you should inform your practitioner if you are receiving treatment or taking medication for other conditions, particularly diabetes, cancer, osteoporosis, asthma or clotting disorders.
- As the consultation progresses, you may then (*rarely*) be asked to remove some of your clothing so that a series of observations and biomechanical assessments (*usually structural techniques*) can be made to attempt to identify points of weakness or excessive strain throughout the body.

YOU SHOULD ASK QUESTIONS:

- May you have any concerns or discomfort during the treatment, and also if you are not comfortable with certain forms of treatments / equipment or do not wish to receive other forms of treatment that may be available within the practice (*e.g., using probe, ultrasound, etc.*) tell the practitioner.

AFTER THE SESSION:

- PHHC Osteopathic Center is following a very sharp quality and satisfaction process.
- So, if any of the previously mentioned points have not been addressed, we encourage you to mention it to one of our PHHC Angel and ultimately raise a complain. All matters raised are addressed within 24h.

I have understood these statements and I hereby acknowledge that:

- | | |
|---|-------------------------------------|
| • I understand the nature of the treatment to be provided to me. | ☐ I disagree |
| • I have considered the benefits and risks of treatment, as well as the alternatives to treatment. | ☐ I disagree |
| • I hereby consent to Osteopathic treatment as proposed to me. | ☐ I disagree |
| • I grant PHHC- Osteopathic Center permission to contact me directly. | ☐ I disagree |
| • I agree that healthcare provider(s) involved in my care at this facility will access my health information through the Health Information Exchange System (NABIDH) in accordance with the Laws of the United Arab Emirates, Emirate of Dubai Legislation and Dubai Health Authority Policies. | ☐ I disagree |

PATIENT'S OR GUARDIAN'S SIGNATURE:

DATE: / /



WHICH OF OUR PRACTITIONERS IS PROVIDING YOU THE CARE?

☐ DR D. BOUDET

☐ DR F. ABDELJALLAL

☐ DR C. LE BERRE

As a Patient Centered Health Center, we need to work closely with your doctor.

This will allow us to establish a full diagnosis of the problem and it will enable us to tailor the treatment plan to your needs. To ensure the best recovery efficiency possible the practitioner may contact your doctor, with your permission.

I hereby consent to PHHC Osteopathic Center 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.

General Practitioner's Full Name *(In Capital Letters)*

STATEMENT OF CONSENT FOR PATIENTS AGED BELOW 18

I confirm that I have read and understood the above information, and I consent, as parent, guardian or appointed care to this patient receiving treatment at this time.

I understand that they can refuse treatment *(or any part of treatment)* at any time in the future without jeopardizing future treatment at this practice.

Signature

Date.....

Full Name *(In Capital Letters)*

STATEMENT OF CONSENT FOR ADULT PATIENTS

I confirm that I have read the above information and I have had the opportunity to discuss any concerns with the concerned practitioner *and* have understood what has been explained to me.

I consent to receive treatment, but I understand that I can refuse treatment *(or any part of treatment)* now or in the future without jeopardizing future treatment at this practice.

I understand that it is important that I inform my practitioner of any concerns, reactions or discomfort associated with treatment.

I understand that I can also request to see another practitioner at this practice.

Signature

Date.....

Full Name *(In Capital Letters)*

Practitioner's Signature:

Date: / /

Time:

Patient's ERP ID N°: