Welcome to New Hope Chiropractic!

**Before we get started, we want to welcome you to our clinic**. There is a good chance that you were referred to us by a friend, colleague, or family member and you’ll soon understand why we have earned their trust – enough so that they would recommend you to us! We truly look forward to earning that same amount of trust from you and the trust of your friends, family, and colleagues.

We wish to begin by letting you know of a few policies we have in place to provide you with the best care and most accurate results and service. If you feel that you would be unable to perform any of these policies or have any disagreement – then please let our front desk staff know and we can provide you with a list of other competent and able providers in this area.

**WE AGREE**

To provide you with the best health care, we will perform what patients typically later describe to us as their **most thorough consultation ever**. Today, we will perform a consultation and evaluation. This allows us to have a complete health profile and a better understanding of your symptoms. We can then make recommendations that will provide you the quickest relief and a plan of action to increase your overall level of health. We will deliver you these results, your *Report of Findings*, as soon as your schedule allows.

**YOU AGREE**

You *Report of Findings* is personalized for your unique situation and your stated goals. Because of this individualized approach, we ask that **anyone involved in the time and financial decision in your household attend** since care at our office is both a time and financial investment. We will be discussing your unique recommended plan of care and financial options at that time.

Consent for Care

CFT at NHC has only one goal, the identification, location, reduction, and correction (if possible) of fascial restrictions. Fascial restrictions are tightness in connective tissues that can restrict the body’s movement, flexibility, and function. CFT is intended to reduce these distortions, thereby allowing the body’s inborn healing ability to work more efficiently. Restoration of health is different for each individual and may happen quickly or slowly, in whole or only in part. We do not offer to diagnose or treat any disease or condition. If we encounter an unusual finding, we may advise you to seek the service of another health care provider who specializes in that area.

I hereby authorize the provider to evaluate and treat my condition as he/she deems appropriate through the use of craniosacral fascial therapy, and I give authority for these procedures to be performed. The provider has discussed the benefits, risks, and alternatives with me, and I therefore give full consent. Furthermore, I agree to the above-mentioned office policies. I also agree that I am responsible for all bills incurred at this office. I may obtain copies of my file upon request. Copying fees may apply.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_