Dmitro Jovnyruk Manual Therapy
416-508-2069
djovnyruk@canadianosteopathy.ca

PATIENT CONSENT FOR TREATMENT

All information collected will be kept strictly confidential according to PHIPA guidelines

I, _____, give consent for Dmitro Jovnyruk to assess and treat me within his scope of practice as a student of osteopathic manual therapy. I understand that Dmitro is currently in his third year of education at the Canadian Academy of Osteopathy, and continuing his training to become an Osteopathic Manual Practitioner. I acknowledge that I cannot claim any treatment fee with my private insurance as Dmitro is not yet a member of an accredited osteopathic association and will not be eligible until his graduation, and he is ***unable to provide receipts*** for any fees associated with treatment he provides.

I am aware that Dmitro cannot diagnose and treat medical conditions, and that ***I have disclosed any diagnoses or conditions*** that may make it unsafe for me to be treated and will discuss any changes in my condition with him. I understand that osteopathic therapies are ***not a substitute for medical assessment and treatment*** from a physician, and that it is recommended that I consult with my family doctor for any physical or mental illness or ailment.

I acknowledge that along with the benefits of osteopathic manual treatment, there are possible reactions (headache, muscle and joint aches, soreness, or discomfort) which may last up to 72 hours after treatment.

I may withdraw my consent to all or any part of treatment by notifying Dmitro verbally or in writing at any time, even in the middle of treatment.

Name:	Phone number: (____) ____ - _____
Signature:	Date (MM/DD/YYYY): ____/____/_____