

# BELMONT WELLNESS CENTER

5803 Wilkinson Boulevard Belmont NC 28012 (803) 230-3111

## AUTHORIZATION TO TREAT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions if you do not understand.

**Risk:** The clinical treatments and therapies we provide are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. Belmont Wellness Center will not give care if he/she is aware that such care may be contraindicated. Belmont Wellness Center will make every reasonable effort during the examination to screen for such contraindications, however it is the responsibility of the patient to make it known or learn through health care procedures whether he or she is suffering from latent defects, illness, or deformities that would otherwise not come to the attention of the Belmont Wellness Center.

I have had an opportunity to discuss with a representative of Belmont Wellness Center the nature and purpose of the treatments or therapies. In understand the results are not guaranteed.

I understand and have been informed that in extremely rare cases as in the practice of medicine, in the practice of kinesiology, massage, physical therapy, and fitness exercises there are some risks, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect Belmont Wellness Center to be able to anticipate and explain all risk and complications, and I wish to rely on the practitioner to exercise judgement during the course of therapy or treatment which the practitioner feels at the time, based upon the facts then know to him/her, is in my best interest.

**Certification:** I have read, or have been read to, 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 therapies and treatments. 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. I hereby request and consent to the therapies and treatments including various modes of physical therapy and diagnostic x-rays (or on the patient's name below, for whom I am legally responsible) by the Belmont Wellness Center.

---

Patient or Legal Guardian Signature

---

Date

---

Witness Signature

---

Date