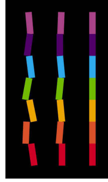

Alamo Heights Chiropractic

HEALTH CENTER

Authorization for Massage Therapy

I authorize Dr. Sandra Carrell Tremblay D.C. (and whomever she designates as her associates and assistants) to administer massage therapy to me which may include procedures considered therapeutically necessary for the treatment of my physical condition. o

I understand that the therapist will administer to me the treatment he/she deems necessary to improve my physical condition. In addition, the therapist will likely give me procedures throughout my treatment for me to perform at home that will assist my recovery, and compliance is necessary to reach outlined treatment goals. o

I understand that the therapist will give me his/her recommendations for a full treatment program based on my overall physical needs and my current physical condition. I also understand that the therapist will give me treatment recommendations for short-term goals to be met which are integral to my full rehabilitative process. o

I understand while Dr. Tremblay and her staff agree to treat me that she can not personally guarantee any results. I understand that the therapist will advise me of advantages and complications, if any, as well as other treatment options, should they become necessary. o

I understand that Dr. Tremblay has a team of physicians she works with and if necessary may refer me to a specialist for a second opinion or further treatment. I authorize the release of any information Dr. Tremblay deems appropriate concerning my physical condition to my insurance company, attorney or adjuster or for procedures scheduled outside this clinic. I release Dr. Tremblay and her staff of any consequence or liability thereof. o

---

Date ____________________________ Patient Signature _____________________________________

Witness _________________________ Guardian ____

4501 McCullough Ave., Suite 107 San Antonio, TX 78212-1619