Informed Consent Statement

I hereby request and consent to the performance of assessment and treatment procedures by Dr. Shannon Asbury. These may include diagnostic procedures and various forms of treatment including, physical and emotional therapy, nutritional supplements, lifestyle and nutritional counselling and remedial exercise as part of my health care program.

I understand that all information about my health care and health history is confidential and is required by Dr. Asbury so that the most effective and beneficial care may be provided. Any communication between Dr. Asbury and myself will remain confidential unless I provide written consent to release it to specifically designated parties or unless Dr. Asbury is legally required to disclose such information.

I understand that any treatment or advice provided to me by Dr. Asbury is not being provided in the place of, or to the exclusion of, any other treatment or advice that I may now be receiving or may in the future receive from a physician, surgeon or any other licensed health care provider.

I further understand and am informed that, as in all health care, there are some very slight risks to treatment. In particular, Matrix Repatterning is a very gentle form of myofascial treatment which may include treatment to the organs of the body and does not have any inherent risks. It is possible, however, to experience an increase of symptoms initially, or fatigue following treatment, or even feel new sensations particularly after the first treatment. These tend to be short-lived (1-3 days) and are considered very normal responses. I also understand that I am encouraged to ask such questions as I may have at any time and to advise Dr. Asbury of any unusual symptoms which may or may not be associated with any of the above procedures or advice provided.

I acknowledge that I am accepting or rejecting this care of my own free will, and that I am free to refuse any treatment or withdraw as a patient at any time. I understand that the ultimate responsibility for my health care is my own and that Dr. Asbury is here to support me in these efforts. I understand that Dr. Asbury reserves the right to discontinue her services where it is apparent that my expectations and the type of services provided are not compatible.

I understand that fees for services are payable at the time of the appointment and that certain procedures may not be covered by insurance. I hereby agree to pay my account at the conclusion of each and every visit.

I am at least eighteen years old and I have read the above statement. I have had an opportunity to ask questions about its content, and by signing below, I agree to the above-mentioned procedures. I intend for this consent to cover the entire course of treatment for my present condition and for future conditions for which I may seek the services of Dr. Asbury.

OR

I confirm that I am legally authorized to grant consent to the above for the patient listed below to be treated by Dr. Asbury.

TO BE COMPLETED BY PATIENT OR LEGALLY AUTHORIZED GUARDIAN:

_____	_____
PATIENT'S NAME	SIGNATURE OF PATIENT/GUARDIAN
_____	_____
DR. ASBURY'S SIGNATURE	DATE