Disclosure of Information Agreement

I agree to permit Joy Carey, CHP to release treatment information and dates of treatment to the following healthcare providers:

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Signature_____Date_____

Consent For Treatment Agreement

I consent to receive treatment from Joy Carey, CHP. The treatment will include, but not be limited to manual therapy and bodywork, stretching, and movement education.

I understand that Joy Carey does not treat, prescribe for, or diagnose any illness, disease, or any other physical or mental disorder, injury, or condition.

Nothing said or done by this practitioner should be construed as such. I further understand that this practitioner is not attempting to practice medicine, osteopathy, chiropractic, physical therapy, psychology, or any other profession requiring a license under the laws of the state of Pennsylvania.

I understand that it is necessary for this practitioner to touch my body in order to assist me in releasing tension, establishing balance, and alignment in my body. I give this practitioner my permission and consent to do all those things necessary in helping me establish balance and alignment.

Signature_____Date_____