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FROM OUR REGULATORY BODY, WE ARE TO DISCLOSE ANY PROCEDURE, WHICH MIGHT BE CONSIDERED EXPERIMENTAL OR INVESTIGATIONAL.

PLEASE CAREFULLY READ THE FOLLOWING:

EXPERIMENTAL TECHNOLOGIES DEVICES OR PROCEDURES

I, have been advised and am aware that Torque Release Technique and Cranio Sacral Therapy would be considered experimental procedures as they are not presently taught in the core curriculum at a CCE accredited chiropractic college.

I have been informed that peer reviewed scientific papers have been published with these techniques demonstrating positive outcomes for the individual receiving it.

I have been advised that there are no risks associated beyond the signed consent form which was read and signed upon my acceptance as a patient.

I understand that the use of either of these procedures does not guarantee a “cure” of a specific condition.

I have read and accept this information and I also understand that I have the right to refuse either of these techniques and chiropractic care at any time.

DATE: _____

SIGNATURE: _____

PRINT NAME: _____

WITNESS: _____