VALLEY WHOLISTIC

Informed Consent

to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office of clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of the chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, 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 procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

Patient's Name: _____

Signature: _____

Date Signed: _____

To be completed by patient's representative if patient is a minor or is physically or mentally incapacitated.

Patient's Name: _____

Name of Representative: _____

Signature of Rep.: _____

Relationship/Authority: _____

Date Signed: _____

To be completed by staff:

Name of Clinic: Valley Wholistic Health Center
Address: 22030 Clarendon Street, Suite 101
Woodland Hills, CA 91367
Telephones: 818-887-4000 / Fax 818-887-7092

Witness to Patient's Signature:

_____

Date Signed: _____

Attending Physicians:

❑ Dr. Kevin Hummel ❑ Dr. Bernadette Rosenstiel

_____

Translated by:

_____

Date Translated: _____