Informed Consent to Chiropractic Treatment

Valley Center Chiropractic and Holistic Care
At The Courtyard
28714 Valley Center Rd., Valley Center, CA 92082 760-500-6253

I, ____, hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, sending me for diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible representative: ______________________) by Dr. John H. Maher, DBA Valley Center Chiropractic.

I have had an opportunity to discuss with Dr. John Maher the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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

As a patient, it is my responsibility before receiving treatment to make known in writing all significant diseases, symptoms, defects, deformities, implants, and injuries I have suffered and all significant medications, treatment surgeries and diagnosis which I have received, even if not related to my primary symptom for which I am seeing Dr. Maher which would otherwise not come to his attention.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

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

_______________________________ ________________________ Date ____/____/____
Signature of Patient Signature of Representative

Dr. John H Maher's Signature ___________________________ Date _____/_____/________

PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF

NUTRITIONAL RESPONSE TESTING™

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Valley Center Chiropractic and Holistic Care to perform a Nutritional Response Testing (NRT) health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing. This permission form applies to subsequent visits and consultations.

Date: ____________________

Print Name: _______________________________________

Address: ____

City _____________________ State ____ Zip _________

Phone: (____) _____ - ________________

Signed: ____

(If minor, signature of parent or guardian required)

Witness:____