Northwest Health & Healing Center

PATIENT INFORMED CONSENT

Name_________________________Date_________________

Address____

City_______________Zip_________Phone________________

I, the undersigned, hereby request and consent to the performance of chiropractice manipulations and other chiropractic procedures, including various modes of physiotherapies, physiological therapeutics (e.g. vitamin/mineral supplements, botanicals, homeopathic preparations, etc.) on me (or the patient named above, *for* whom I am legally responsible) by Dr. Rolland House or Dr. Michael Sorah.

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 sprain and strains, fractures, strokes, general aggravations of inflammatory conditions, nutrient-drug and nutrient-nutrient interactions. I understand that I will have an opportunity to discuss with the doctor the nature and purpose of chiropractic manipulations and other procedures. I understand that the doctor will perform and examination in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications, therefore wish to rely on the doctor to exercise professional judgment during the course of the procedure, which the doctor feels at the time, based upon the facts as then known, is in my best interests. Finally, I understand that Dr. House or Dr. Sorah gives no guarantee or assurance as to the results of these procedures.

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 procedures. I intend for this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature________________________________Date______________

Doctor's Signature______________________________________Date_______________