Informed Consent for Treatment at ChiroWellnessLA

I hereby request and consent to the performance of body work and soft tissue work, on me (or on the patient name below, for whom I am legally responsible for) by the Therapist or his appointed assistant, intern or associate. I understand that my information may be shared with our partners and associates at Serenity Phoenix Wellness but will never be shared or sold with any entities beyond that.

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

I have read or have had read to me, the above consent. In addition, I have had the opportunity to ask questions about its content. 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 and for any future condition(s) for which I seek treatment.

____
Patient's Name (Printed)

____
Patient's Signature

____
Signature or Parent of Guardian (if a minor)

__________/___________/ 20_______
Date

Joshua Naparstek, D.C., 5444 Yolanda Ave. Suite 210, Tarzana, CA 91356
(818) 403-4401 Dr.Josh@ChiroWellnessLA.com