Harmony Heals, Inc

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 the patient below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I understand and I am informed that in the practice of chiropractic, as in the practice of medicine, 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 or explain all risks and complications. I wish to rely on the doctor to exercise judgment based on the facts known at the time of service based on my best interests, during the course of treatment.

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

To be completed by patient:

_____ _____ Date:_____

Patient's Name (print) Patient's Signature

To be completed by patients representative If patient is a minor or incapacitated:

_____ _____ Date:_____

Parent or Legal Guardian's Name Parent or Legal Guardian's Signature

Female Patient's Only:

This is to certify that to the best of my knowledge, I am **NOT** pregnant and that Dr. Homa Bakhtar has my permission to take x-rays. (Please enter the first day of your last period): _____ / _____ / _____

_____ Date:_____

Patient's Signature

This is to certify that to the best of my knowledge, I **AM** pregnant and that Dr. Homa Bakhtar does not have my permission to take x-rays. Please enter how many months/weeks pregnant you are:_____

_____ _____ Date:_____

Estimated Due Date Patient's Signature

Name and Address of Clinic:
Harmony Heals, Inc
24351 Moulton Pkwy, Suite 120
Laguna Woods, Ca 92637

Doctors Treating this Patient:

Homa Bakhtar, D.C