numinosity

Informed consent for routine clinic services (excludes psychotherapy)

***Patient Name**: _____*

Please initial and date the following consents for services received.

_____**CONSENT TO ROUTINE CHIROPRACTIC SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Christina Yogerst, DC, Suzana Levy, DC, 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 for the doctor of chiropractic named above. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic manipulative therapy, 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, and is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

_____**CONSENT TO ROUTINE MASSAGE SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Lyn Hughey, Gina C. James, Marsha Hansen and/or other licensed massage therapists who now or in the future treat me while employed by, working or associated with or serving as back-up for the massage therapist named above. I understand and am informed that, in the practice of massage therapy there are some risks to treatment, including but not limited to sore muscles and joints, increased risk of emboli from varicose veins, and increased blood pressure from hypertension. I do not expect the massage therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the massage therapist to exercise judgment during the course of the procedure which the massage therapist feels at the time, based upon the facts then known, and is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

_____**CONSENT TO ROUTINE ACUPUNCTURE SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Toshio Omura, L.Ac and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above. I understand and am informed that, as in the practice of medicine, in the practice of acupuncture, there are some risks including but not limited to bruising, bleeding, blistering, pneumothorax, or fainting. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, and is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

I, OR MY REPRESENTATIVE, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I HAVE RECEIVED A COPY OF THIS INFORMATION.

_____ _____ _____ _____

Signature of Patient | Date | Signature of Insured/Agent | Date

If patient is under the age of 18, or is otherwise unable to sign, please complete the following:
Patient is _____ years of age OR unable to sign because: _____

_____ _____ _____

Signature | Date | Relationship to patient

Gina C. James, LMT, #7348 | Christina O. Rose, LPC, LLC | Marsha Hansen, LMT
Suzana Levy, DC, LLC | Lyn Hughey, LMT, #5191 | Christina Yogerst, DC, LLC | Toshio Omura, L.Ac
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