AUTHENTIC HEALTH

NUTRITION • CHIROPRACTIC • COLD LASER

Informed Consent

AuthenticHealthLLC.com

Name: _____

CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests and Physical Therapy techniques by Dr. Jill Balla, DC of Authentic Health LLC and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for Dr. Jill Balla, D.C. and understand that I can decline treatment at any time. I have had an opportunity to discuss with the doctor of chiropractic and/or with office personnel the nature and purpose of chiropractic adjustments and other procedures and have had my questions answered to my satisfaction. 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 fractures, disc injuries, dislocations, muscle strain, costovertebral strains/separations, diaphragmatic paralysis, cervical myelopathy and Homers' syndrome. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known to her or him, is in my best interest. I understand that results are not guaranteed and there is no promise to cure.

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for the use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease." A vitamin is not a drug, neither is a mineral, trace element, amino acid, herb or homeopathic remedy. Although, a vitamin, mineral, trace element, amino acid, herb or homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. I understand that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, EAV testing, muscle testing, supplement recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of the eight chemical components of the Vertebral Subluxation Complex.

CONSENT FOR SERVICES

I consent to services I choose to receive performed by qualified health care practitioners at Authentic Health LLC such as, but not limited to, Manual Therapy, CranioSacral Therapy, Massage Therapy, Myofascial Release, Reiki, Vibration Plate, Raindrop Technique, use of Essential Oils, and Cold Laser Therapy. I understand and am informed that, as in the practice of medicine, with any therapies there are some risks with treatment. I do not expect the health care practitioner to be able to anticipate and explain all risks and complications, and I wish to rely upon the health care practitioner judgment during the course of the therapy(ies) which the she/he feels at the time, based upon the facts then known to her or him, is in my best interest. I understand that results are not guaranteed and there is no promise to cure.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of information including appointments, diagnosis, records, examination and claims information by Authentic Health LLC to the following: (mark all that apply)

- ☐ Spouse: _____ (list full legal name)
- ☐ Family Member(s): _____ (list full legal name(s)
- ☐ Other: _____ (list full legal name(s)
- ☐ My information is not to be released to anyone.

I have read, or have had read to me, understand and agree to this INFORMED CONSENT and AUTHORIZATION TO RELEASE MEDICAL INFORMATION and I have had the opportunity to ask questions concerning this form. 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. Any previous agreement is hereby superseded, replaced in its entirety and considered null and void.

Patient Name (print)	Patient Signature	Date
Parent/Guardian Name (print)	Parent/Guardian Signature	Date