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NOJI CHIROPRACTIC --------------------
--------------------& WELLNESS CENTRE

Dr. Janice L. Noji, D.C. *
Dr. Matthew Noji, D.C. *

Informed Consent to Assessments & Laser Therapy

I hereby request and consent to the performance of assessments, laser therapy, various modes of physical therapy, and other procedures, on me by the practitioners listed at this clinic and or anyone working at this clinic authorized by the practitioners.

I have had the opportunity to discuss with the practitioners listed at this clinic, the nature and purpose of assessments, laser therapy ,various modes of physical therapy, and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of laser therapy , there are some risks, including but not limited to short term aggravation of symptoms. When used in combination with certain medications laser therapy can cause burns and I therefore understand that I must disclose all information on my current medications to the practitioners at this clinic. I also understand that the laser can cause damage to the eyes when viewed directly and that laser safety eyewear, supplied by this clinic, must be worn by me during laser treatments.

I also understand that I may not be a candidate for laser therapy if I have been diagnosed with cancer in the past 5 years or if I have an active infection and I will therefore disclose this information to practitioners at this clinic.

I do not expect the practitioners listed at this clinic to be able to indicate or explain all risks and complications and I wish to rely on the exercise of judgment during the course of assessment and/or procedures which the practitioners feel at the time, based upon the facts known, is in my best interest.

I acknowledge I have discussed, or have had the opportunity to discuss, with my practitioner or anyone working in this clinic authorized by my practitioner, the nature and purpose of my treatments as well as the contents of this Consent.

I consent to the assessments, performance of laser therapy and various modes of physical therapy, including but not limited to chiropractic and laser therapy, offered or recommended to me by the practitioners in this clinic. I intend this consent to apply to all my present and future care in this clinic.

Dated this____________________day of________________________________, 20_________.

Patient/Guardian Signature: ______________________________

Witness of Signature: ______________________________

Name of Patient: ______________________________

Name of Witness: ______________________________

Clinic Practitioners as of above signed date: ______________________________