James D Martin D.C., C.C.S.P.
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Valley CHIROPRACTIC CLINIC, INC

400 N Main St
Wasilla, AK 99654
92-0139651
Phone: 907-373-2022
Fax 907-373-2029

Informed Consent

I (the patient/guardian) hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and massage or soft tissue therapy on myself (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named above and/or other licensed Doctors of Chiropractic who now or in the future work at Valley Chiropractic Clinic, Inc.

I have had an opportunity to discuss with the Doctor of Chiropractic and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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, 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 judgement during the course of procedure which the doctor feels at the time, based upon the facts then known to him of her, is in my best interest.

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 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 Name_____Signature_____Date_____

Parent/Guardian Name_____Signature_____Date_____

Telephone Message and/or Appointment Reminder Consent:

I_____give Valley Chiropractic Clinic, Inc. and members of its staff working at the location indicated above my permission to call me.

I would prefer to be called at (fill in all that apply and place a mark next to the highest preference)

Yes, this office may leave (check all that apply):

Home:_____ _____Voice mail at my home
_____Messages with people at my home

Work:_____ _____Voice mail at my work
_____Messages with people at my work

Home:_____ _____Voice mail on my cell
_____Texts on my cell

Patient Name_____Signature_____Date_____

Parent/Guardian Name_____Signature_____Date_____