

Carranza Chiropractic and Sports Therapy

4494 W. Peoria Ave., Ste. 116

Glendale, AZ 85302

(623) 252-1512 • Fax (623) 334-0182

Date _____

I, _____
(print patient's name)

authorize the performance upon myself of the following procedures: Chiropractic manipulation, hot/cold packs, electrical muscle stimulation, interferential therapy, and ultrasound to be performed by or under the direction of Dr. Noe Carranza as clinically indicated.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above-named doctor, associates or assistants, may consider necessary or advisable in the course of my health care.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above-named doctor and/or his associates and assistants.

I acknowledge that no guarantee or assurance of the results that may be obtained from the procedure has been given by the above-named doctor, his associates or assistants.

Date _____ Signature _____

Witness _____ Relationship _____