Dr. John A. Podlaski
DC, DACBN, DABCI, DCBCN, CNS, FIAMA
8564 East County Road 466
Suite 206
The Villages, FL 32162
P: 352-801-0021

DISCLOSURE, INFORMED CONSENT, PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF EXAMINATION PROCEDURES, LABORATORY TESTING AND ASSESSMENT, ACUPUNCTURE, APPLIED KINESIOLOGY, LENS NEUROFEEDBACK THERAPY, NUTRITION RESPONSE TESTING™, NUTRITIONAL/ NUTRACEUTICAL THERAPY, NUTRI SPEC METABOLIC BALANCE TESTING, NEURO EMOTIONAL TECHNIQUE AND SUBSEQUENT TREATMENT(S)

PLEASE READ BEFORE SIGNING

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended testing procedures, laboratory tests, costs and other physical procedures to be used so that you may make the decision whether or not to undergo the procedures after knowing the potential risks and hazards involved. We will inform you of what costs, methods, tests, procedures, treatments and possible treatment alternatives may be utilized or recommended in your particular case. Dr. Podlaski does not practice Allopathic (MD) medicine but is licensed only for the practice of Chiropractic Medicine including clinical nutrition, natural holistic drugless health care, and is certified in acupuncture by the Florida Board of Chiropractic Medicine.

Dr. John A. Podlaski, DC, NMD, DABCI, DACBN, DCBCN, CNS, FIAMA offers a variety of physical examination procedures, laboratory testing for the purpose of biochemical assessment of the patient, and natural therapies and modalities of which all or some may be used in your care in our office without the use of surgery or prescriptive drugs. Among them are Applied Kinesiology, acupuncture, chiropractic manipulation, diet, lifestyle, nutrition, herbal and botanical medicines, homeopathic medicines, LENS Neurofeedback Therapy, Neuro Emotional Technique (NET).
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 the procedure(s) or treatment(s) which the doctor feels at the time, based upon the facts then known, is in my best interest.

Florida Law requires that patients be made aware of potential alternative treatment options in addition to the natural medicine recommendations from this office regarding their health and conditions. Alternative traditional treatments not offered at this office may include: medication, surgery, or Physical Therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, your condition could get worse, remain the same, or improve. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure(s)/treatment(s).

Since a nutritional deficiency may or may not be associated with a specific disease, or it may be the cause of the disease, or it may occur as a result of that disease, it is important for you to understand fully that our sole concern in your case may be your personalized nutritional program and your ability to metabolize and utilize the nutrients that you consume.

We will not diagnose, treat or cure any specific disease and the nutritional and other treatment recommendations we make are based on laboratory tests, physical exam findings, clinical evaluation, history and symptoms, and does not constitute treatment for any disease or affliction real or imagined by you.

In the nutritional management of a case we may routinely recommend minerals, vitamins, enzymes, homeopathics, phytonutrients, herbs and other nutritional substances… and we do not want you to have any misconceptions about their use in this office. In the event that any vitamin, mineral, herb, homeopathic, food or other nutritional substance is recommended in your case, we want you to understand explicitly that its purpose will be for:

1. The improvement of your overall nutritional status;
2. To improve your metabolism;
3. For the improvement of the overall sense of wellbeing;
4. To improve appetite;
5. For gain or loss of weight;
6. For possible remission or reduction of pain when present

However, you must understand that you may not receive any of these benefits because they do not occur predictably with every patient and in rare cases, they may not occur at all.
Therefore, in consideration of the aforementioned information, conditions and explanations

1) I hereby specifically request, consent and authorize the performance of the various necessary physical examination procedures, diagnostic testing and laboratory tests which have been or will be fully and completely explained to me beforehand including cost by the Doctor of Chiropractic medicine named above and/or other licensed Doctors of Chiropractic or those designated staff working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic medicine named above, **with this I give my informed consent to proceed.**

2) I hereby request and give my consent to the Doctor of Chiropractic medicine named above to develop a natural, complementary health improvement program for me which may include but may not be limited to dietary, lifestyle guidelines, nutritional supplements, acupuncture, exercise or other appropriate therapies, treatments or procedures etc. I understand that they will be fully explained to me at my report of findings visit including the risks (if any) of such procedures, recommendations and treatments in order to assist me in improving my overall health and **not for the treatment, or "cure" of any disease.** I will have the opportunity to discuss with the Doctor of Chiropractic medicine named above, my diagnosis, the nature and purpose of the recommended nutritional therapies or other procedures and treatments and then decide if I want to proceed with those procedures, recommendations and treatments

3) 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 professional judgment during the course of the procedure(s) or treatments which the doctor feels at the time, based on the facts then known, is in my best interest.

4) I further acknowledge that no guarantees or assurances will be made to me concerning the results intended from the recommended treatment(s), but rather I understand that these treatment recommendations may be a means by which the body's natural, innate healing ability can be utilized so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

5) I intend that this permission/consent form applies to subsequent visits and consultations to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

6) Before you sign this agreement and consent, we want you to understand that our viewpoint concerning nutrition and the need for certain nutrients or any of the other recommended treatment programs/procedures is not necessarily shared by the American Medical Association, The Food and Drug Administration and quite possibly other similar agencies.

To be completed by the patient:

Date:_____

Print Name: _____

Address: _____

City _____ State ____ Zip_____

Phone: (____) _____ - _____

Signed: _____

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated or translated by another person:

Print Name: _____

Print Name of patient's representative: _____

Signature of patient's representative: _____

As: _____

(relationship or authority of patient's representative)

Date signed: _____

To be completed by doctor or staff:

Witness: _____

Date: _____