• S O H M A •
INTEGRATIVE HEALTH CENTER

SCU Intern Consent

I have been informed that the doctor providing my treatment in this office has been certified as Associated Faculty within the Clinical Internship Division of the Los Angeles College of Chiropractic, and that this office serves as a teaching as well as a treating facility. I understand that an intern, under the direct supervision of the doctor, may provide some of the treatment that I receive in this office. I understand that an intern will be identified as such prior to their involvement in any treatment that I receive.

I hereby request and consent to examination and the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor, or by an intern under the direct supervision of the doctor.

I have read the above consent, by signing below I agree to the above, and allow the doctor or intern, affiliated with the Los Angeles College of Chiropractic to perform such. 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's Name (Printed) Date

_____

Patient or Guardian's Signature