CONSENT FOR TREATMENT

Injury Care Network, L.L.C

Medical Doctors
- Jon Shick, D.O.
- Bethany Wallace, D.O.

Nurse Practioner
- Kerrie Beyer, MSN, APRN, F.N.P

Neuropsychologists
- Georganne Bley, Ph.D.
- Judith Holland, Ph.D., Traumatologist

Psychologists
- Ron Schwenkler, M.A.,LPC
- Audra Mitchell, Biofeedback

Acupuncturists
- Kyle Gill, M.S.O.M.,L.Ac.
- Ignacia Genco L.Ac.

Podiatrists
- Michael Schneider, D.P.M.

Neuro-Optometrist
- Edwin Manniko, O.D.

Rehabilitation Services, L.L.C
- William Miller, M.D.,M.P.H.
- Veronica Reza, F.N.P.

W. Rafer Leach M.D.

Movement Dynamics Physical Therapy, P.C.
- Shawna Roberts, PT, M.S.P.T
- Elizabeth Ford, PT, D.P.T
- Emily Gee, PT, D.P.T, FYT
- Kacper Kazibut, PT, D.P.T
- Melissa Kliem, PT, D.P.T
- John Phillips, PT, D.P.T., CSCS
- Eva Steiner, PT, D.P.T

Synergy Chiropractic Clinic, P.C.
- Bruce Latta, D.C.
- Kevin Duncan, D.C.
- Gregory Ingram, D.C.
- Greg Karraker, D.C.
- Richard Lewellen, D.C.
- Daniel Younger, D. C.

I hereby authorize the above referenced provider(s) and whomever (s)he may designate as his/her assistant(s) to administer treatment, as necessary, for the care of ___________.
I understand that the practice of medicine is not an exact science and there are no guarantees of the results and that every individual may respond differently to a particular treatment regimen. I understand that there are certain risks associated with an examination or treatment and those risks have been presented and explained to me.

IMPORTANT NOTICE TO THE PATIENT:
Please note, we will be developing a treatment plan in order to facilitate a complete recovery from your injuries. But in order to do so, your assistance is needed. We ask that you make arrangements to make appointments according to your treatment plan. If there is a compliance issue, we will need to make the attorney aware of the situation.

____ Date: ____________
(PATIENT / PARENT / LEGAL GUARDIAN SIGNATURE)