CONSENT FOR EXAMINATION AND TREATMENT

I, ____, do hereby consent, authorize and request Dr. Andrijana J. Pitruzzello, DC to administer such exams and/or treatments deemed advisable. I understand that the purpose of any performed exam is to test the integrity of my health and to thereby have the best care recommended for me. I understand that some of the exams are intended to be provocative in nature in order to highlight what underlying conditions I may have, and as a result may cause aggravation of these underlying conditions. I agree to hold these doctors free and harmless from any claims, suits for damages or complications that may result from such exams and/or treatments.

Patient Signature ____ Date ____________