



FIT Wellness Center
1140 US Hwy 287, Ste 100
Broomfield, CO 80020
(303) 469-0353 Office
(303) 469-1066 Fax
info@BroomfieldWellness.com

INFORMED CONSENT TO AN “UNPROVEN” OR “EXPERIMENTAL” PROCEDURE

Caution

This informed consent warns you that certain procedures are “unproven” or “experimental” by the Colorado State Board of Chiropractic Examiners. Do not sign it until you have read it and had the procedure explained to you, and until you have received answers to any questions you may have.

The following procedure, protocol, analysis or methodology has been designated as “unproven” or “experimental” by the Colorado State Board of Chiropractic Examiners: Laser therapy. Its effectiveness has not been demonstrated. **(The FDA, in 2002 has approved Laser Therapy for the Neck & Shoulder as well as Carpal Tunnel.)**

I, _____, understand that the above referenced procedure, protocol, analysis or methodology has been designated as “unproven” or “experimental” by the Colorado State Board of Chiropractic Examiners, and that its effectiveness has not been demonstrated. I hereby consent to the use of Laser therapy, and give my express permission to proceed. I understand that this procedure may not be covered by my insurance plan because of the fact that it has been designated as “unproven” or “experimental”. I have read the above informed consent. I understand the procedures and grant permission for my doctor to proceed. I acknowledge receiving a signed copy of this form.

Date

Patient signature

Patient’s printed name

OR

Date

Patient’s legal representative or guardian

Patient’s legal representative or guardian printed name