Dr. John P. Salerno

Board Certified Family Physician

Phone (212) 582-1700
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THE SALERNO CENTER CONSENT FORM

You have come to this office requesting treatment from The Salerno Center. The specific form of treatment you receive, as noted below, may be considered experimental by many doctors. The usage of this treatment may have been disapproved by medical groups on the grounds that such treatment has not been shown to be safe or effective usual, customary and reasonable. It is important for you to realize this because we must have your informed consent in order to proceed with the treatment.

With regard to the financial cost of the treatment, we cannot guarantee reimbursement from your insurance company. We will expect prompt payment and reserve the right to discontinue treatment for your failure to pay in a timely manner.

The choice of whether or not to enter this treatment is yours. Should you decided to discontinue the treatment after you have started it, you have the right to cease at any time and choose other treatment elsewhere.

Although we do believe that this treatment will be of benefit to you, and that it has helped others, you must understand that we cannot and we so not warrant or guarantee the results in any manner. I cannot offer this procedure to you except upon the condition that you release my office and myself and any treating persons from any legal responsibility for harm resulting from its use in your case.

Your signature on this agreement will constitute a full and final release of any legal responsibility resulting from the administration of this treatment as therapy in your case and/or any other medical treatment that may be necessary as a result thereof.
The specific treatment is _____

I have read the description of the therapy as outlined herein or I have had it translated into a language I understand. I understand that my taking this treatment is voluntary, and I understand there are other forms of treatment I could have chosen.

_____ _____

John P. Salerno, D.O **Patient's Signature**

_____ _____

Date **Patient's Name** (*please print clearly*)

Witness: _____ **Date:** _____