



INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy, physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below or any other office or clinic.

I understand that I can at any time discuss with the Doctor of Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on facts then known, is in my best interests.

I have read or have had read to me the above consent. I understand that I am able to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT OR PATIENT’S REPRESENTATIVE, IF NECESSARY, E.G., IF THE PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED:

_____ Date: _____
(Print Patient’s Name) (Signature)

_____ Date: _____
(Representative’s Name) (Relationship)

Witness to Patient’s Signature: _____ Date: _____

Treating Doctor of Chiropractic: _____

THE SIGNED ORIGINAL IS TO BE FILED IN THE PATIENT’S FILE; COPY IS AVAILABLE FOR THE PATIENT AT THEIR REQUEST