

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or 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 backup for the doctor or chiropractic named below, including those working at the clinic or office below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

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, fracture, disk 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 upon the facts then know, is in my best interests.

I have read or have had to me, the above consent. I have also had the opportunity to ask questions about its contents 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 future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name: _____ Date signed: _____
Please Print

Patient's Signature: _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name: _____ Date signed: _____
Please Print

Patient's Signature: _____ Signature if Representative: _____

Relationship or Authority of Patient's Representative: _____

Translated by: _____ Date: _____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office: _____

Address: _____

Name of Doctor's treating this patient:

1. _____ Pin# _____

2. _____ Pin# _____

3. _____ Pin# _____