



Informed Consent To Chiropractic Treatment

I here by request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, diagnostic x-rays, physiotherapy, and physical therapy procedures on me by the doctor of chiropractic at this office and/or other assistants and/or licensed practitioners at this office

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) and/or with office personnel at this office the nature, purpose and risks of chiropractic treatments and other recommended procedures. I also understand that specific results are not guaranteed.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Printed name of Patient

Signature of Patient

Date

Signature of Representative (if patient is minor or handicapped)

Date

Witness to Patients' Signature

Date