INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT & CARE

I have been informed that it is not uncommon for patients to have some increased discomfort after an adjustment. If this occurs, I will apply ice to the area (as instructed) and rest. If I am concerned about this discomfort or develop new symptoms, I can call the clinic phone number 24 hours a day and reach the doctor on call for emergency attention. If out of town, or unable to contact the doctor, I can present myself to the emergency room.

If any test were performed outside this office (laboratory or other diagnostic procedure) I understand the doctor will notify me of the results when the report becomes available.

I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modalities of physical therapy and if necessary, diagnostic radiographs (x-rays) by the doctor of chiropractic in this office or anyone in this office authorized by the doctor of chiropractic.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks with treatment, including but not limited to muscle strains and sprain, disc injures and strokes, I do not expect the doctor to be able to anticipate and explain all the 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 known, is in my best interests.

I have read the above consent, and by signing below, I agree to the above named procedures. I intent this consent form to cove r the entire course of treatment for my present condition and for any future condition for which I seek treatment.

_____ _____

Name (please print) **Signature** **Date**

_____ _____

Witness **(Date)** **Parent/Guardian** **(for minors)**