

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 physical therapy and diagnostic procedures, 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 or an assistant who now or in the future treat me while employed by or working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic /office named 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 personnel the nature and purpose of chiropractic the adjustment and 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, 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 upon the facts then known, as in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent and by signing below I agree to have 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.

PATIENT

To be completed by patient's representative if necessary, e.g., if patient is a minor or physically or legally incapacitated

PRINT Patients Name

PRINT Name of Patient Representative

SIGNATURE of Patient

SIGNATURE of Patient Representative

DATE Signed

Relationship

Witness to patients signature

Treating Doctor:
Clyde W. Porter, D.C.