Irwin Family Chiropractic Clinic

Informed Consent for Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy on me (or the patient named below, for whom I am legally responsible) by a doctor employed at Irwin Family Chiropractic Clinic, who now or in the future will treat me while employed by, working with, or associated with Irwin Family Chiropractic Clinic.

I will discuss with the doctor, and/or with other office 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 with the practice of medicine, chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. While I do not expect the doctor to be able to anticipate every risk and complication, I consent to rely on the doctor's best judgment, exercised during the course of diagnosis leading to treatment that is in my best interest, based upon the known facts.

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 the above-named chiropractic procedures. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____ _____

Print Patient Name Date Signed

_____

Patient Signature

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

_____ _____

Print Patient Name Date Signed

_____

Signature of Patient's Representative