Informed Consent

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that my doctor will no be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and herby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my doctor.

______________________	______________________	______________
PRINT PATIENT NAME	SIGNATURE	DATE

If patient is a minor:

______________________	______________________	______________
PRINT PARENT/GUARDIAN NAME	SIGNATURE	DATE

I also give permission for my minor child ______________________________ to receive treatment in my absence.

______________________	______________________	______________
PRINT PARENT/GUARDIAN NAME	SIGNATURE	DATE