ADIO CHIROPRACTIC

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination tests, diagnostic x-rays, and physical therapy techniques on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office below or any other office or clinic.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strains and sprains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications; I wish to rely on 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, are in my best interest.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature, purpose and risks of chiropractic adjustments and other procedures and have had my questions answered to my satisfaction. I understand results are not guaranteed.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

_____	_____
Patients Name	Patient Signature
_____	_____
Date Signed	Office Representative