

## **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 by Dr. Parker and/or anyone working in this office authorized by Dr. Parker

I have had an opportunity to discuss with the doctor of chiropractic and/or other office personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some slight risks to treatment, including but not limited to, muscle sprains and strains, disc injuries, and strokes. 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 in which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its contents, and by signing below I agree to the above procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient's Name \_\_\_\_\_ Signature of Patient/Guardian \_\_\_\_\_

Date \_\_\_\_\_ Witnessed \_\_\_\_\_