Please read the complete form and sign the bottom.

At Davis Chiropractic, we do not cure diseases, illnesses, or other diagnoses. However, regular chiropractic care can greatly benefit you and your body. We simply find spinal subluxations, restrictions, and misalignments, correct them by adjusting the body, and we let the body do the rest as the body is a self-healing organism. We offer non-therapeutic care. We do not diagnose or treat any conditions or symptoms.

I acknowledge that I give consent and authorize the doctor at Davis Chiropractic to perform evaluation and management procedures for the purpose of performing an examination and delivering treatment. If, during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. If symptoms ever begin to make you feel suicidal, please seek help at an urgent care facility.

The patient examination process includes important tests that require movement, exertion, and balance control and may result in worsening of symptoms, muscle strain, and falling. I accept these risks and agree that I will provide correct answers and information and I will notify Davis Chiropractic if there has been a change in any of my answers and information.

We, at Davis Chiropractic, cannot share your personal or medical information with any outside party without your approval. By signing below, I authorize Davis Chiropractic to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, communicating with my referring physician (if applicable), and any other administrative operations related to treatment or payment.

I understand Davis Chiropractic does not make any assurances or guarantees. They do not offer anything other than a subluxation diagnosis, or treat any symptoms. They can terminate membership at their discretion. They offer no refunds or reimbursement should I cancel any agreement.

Davis Chiropractic does not accept any insurance. I understand that I am responsible for all charges, and understand payment is due at the time of service.

All memberships are based on a 48-week calendar allowing for personal time away from the office. Barring extenuating circumstances, additional days/weeks will not be added to memberships for holidays or personal time away from the office.

If you have read the consent form in its entirety and you understand & agree to the above statements, please sign below.

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Print Name

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Signature

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Date

**Consent to evaluate and adjust a minor child:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and fully understand the Informed Consent and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Print Name

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Signature

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Date