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KAI CARE
CHIROPRACTIC AND WELLNESS

Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, (either on myself or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic who works for Kai Care, and/or other licensed doctors of chiropractic who currently or in the future treat me while employed by, working with, associated with or doing locum coverage for the primary doctor of chiropractic.

I have had the opportunity to discuss with the Doctor of Chiropractic and/or other office/clinic personnel the nature and purpose of chiropractic adjustments, massage, acupuncture and other procedures. I understand that chiropractic adjustments involve the doctor placing his or her hands on me (or for whom I am responsible) and delivering a very specific, quick thrust or impulse to the involved area(s). Alternatively, the doctor may use an instrument in place of his or her hands. I understand that results are not guaranteed. I also understand and am informed that, as in the practice of medicine, there are some risks associated with chiropractic treatment, including but not limited to fractures, disk injuries, strokes, dislocations, and sprains. 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 procedure based upon what the doctor feels, at the time, is in my best interest.

I have read or had the above consent read to me, and I have had the opportunity to ask questions about its content. By signing below, I agree to the above-named procedures. I intend for 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:_____ Date: _____

Relationship to patient (if signed by a personal representative of the patient): _____