



**Dr Stephanus P. E. Boshoff D.C.; C.Ad; D.A.C.A.C.D., Q.N.C.P.  
BOSHOFF CHIROPRACTIC CENTER**

## **ACKNOWLEDGMENT OF INFORMED CONSENT**

I have read and fully understand the Informed Consent and therefore accept chiropractic care on this basis.

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Print Name	Signature	Date
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### **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.

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Parent/Guardian Signature	Date
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### **Pregnancy Release:**

To my knowledge I am \_\_\_\_\_ weeks pregnant.  
I have read and fully understand the Informed Consent and accept Chiropractic Care during  
my pregnancy.

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Patient Signature	Date
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