Informed Consent for Chiropractic Adjustments and Care

Informed Consent for Chiropractic Adjustments and Care I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at other Glide Chiropractic Care office. I have had an opportunity to discuss with the doctor of chiropractic named below, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as with the practice of medicinal chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts.

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

To be completed by patient:

Print Patient Name: _____ Date:_____

Patient Signature: _____

To be completed by Patient's representatives, if necessary, e.g. if patient is a minor or is physically or mentally incapacitated.

Print Patient Name: _____ Date:_____

Signature of Patient's Representative: _____

GLIDE
CHIROPRACTIC CARE

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