

**DISCLOSURE & INFORMED CONSENT
CHIROPRACTIC ADJUSTMENTS AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy (electric stimulation, ultrasound, rehabilitative exercises, heat/ice) on me (or on 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 work at the clinic or office listed below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

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

To be completed by the patient:

*To be completed by the patient's representative,
if necessary, e.g., if the patient is a minor or is
physically or legally incapacitated:*

Print Name

Print name of Patient

Signature of Patient

Print Name of Patient's Representative

Date Signed

Signature of Patient's Representative

As: _____
Relationship to Patient

Date Signed

To be completed by doctor or staff:

Witness to Patient's Signature

Date

Freeley Chiropractic, P.C.