

## Informed Consent for Chiropractic Care

A patient coming to the Doctor of Chiropractic gives the doctor permission and authority to care for the patient in accordance with chiropractic test, diagnostics and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases underlying physical defects deformities or pathologies may render the patient susceptible to injury. The doctor of course will not give a chiropractic adjustment, or health care, if she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health services. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I hereby request and consent to the performance of the chiropractic adjustment and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below for whom I am legally responsible) by SCHNIPPER CHIROPRACTIC CENTER and/ or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for SCHNIPPER CHIROPRACTIC CENTER.

I have had the opportunity to discuss with the doctor of chiropractic the nature and purpose of chiropractic adjustments and other procedures.

I have read the above consent. I have also had the opportunity to ask question about it's content, and signing below, I agree to the above-name procedures.

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient signature: \_\_\_\_\_

Witness: \_\_\_\_\_

To be complete by patients representative if patient is a minor or physically or legally incapacitated

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_