**Informed Consent**

**To Chiropractic Care**

1045 Robertson St

Ft. Collins, Colorado 80524

Phone (970)223-5914

Fax (970)223-5918

**Please discuss any questions or concerns with the Doctor before signing this consent.**

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 by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other offices or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatment:

Chiropractic Adjustment

I understand that chiropractic is not an exact science; therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

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| Witness Signature Click here to enter signature. | Date Click here to enter a date. |
| Doctor’s Signature Click here to enter signature. | Date Click here to enter a date. |