

{INSERT LETTERHEAD HERE}

CONSENT FOR CHIROPRACTIC SERVICES

1. I, _____, authorize the performance upon myself of the following procedure(s);

Examination and/or treatment

I realize that these procedures are to be performed by or under the direction of chiropractic physicians, employed by {*INSERT PRACTICE NAME HERE.*}

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above named doctor(s), may consider necessary or advisable in the course of my health care.
3. The nature and purpose of the procedures, alternatives, risks and the possible consequences and the possibility of complications have been explained to me by the above named doctor(s).
4. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by the above named doctor(s).

Date: _____ Signed: _____

Witness: _____ Relationship: _____