INFORMED CONSENT TO CHIROPRACTIC CARE

Mountain Spring Chiropractic Center, Inc.

I request and consent to the preformance of chiropractic examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State Law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by any of the testing doctors of chiropractic on staff and/or any licensed chiropractor deemed appropriate by the office. I understand that results of the treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening of symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PRINT Patient's Name: ______________________________

SIGNATURE of Patient______________________________

DATE:____