8711 Windsor Parkway, Suite 7
Johnston, IA, 50131

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments, physical examinations, and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible).

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. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

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

TO BE COMPLETED BY PATIENT

Patient Name ______________________(Please Print) Signature of Patient_________________________

Date Signed_________________________

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR

Signature of Representative_____________________ Date Signed_______________________________

Relationship or Authority of Patient's Representative____