INFORMED CONSENT TO CHIROPRACTIC CARE

Spaulding Chiropractic Clinic, Inc
1221 Noble St., Ste 101
Fairbanks, AK 99701

Telephone : (907) 456-4234

Patient Name _____ Birthdate _____

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 office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below.

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

I understand that chiropractic is not an exact science and that, therefore, reputable practioners 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.

Please discuss any questions or concerns with the Doctor <u>before</u> signing this consent.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Guardian or Personal Representative Date

Witness Signature_____ Date_____

Doctor's Signature_____ Date_____