INFORMED CONSENT AND PATIENT RIGHTS

I (or the minor for whom I am legally responsible) do hereby request and consent to the performance of whatever diagnostic tests, chiropractic manipulative therapy, and any other health care procedure including but not limited to, nutrition or natural medicine, physio-therapeutics, neurological retraining, and or rehabilitation that the doctor deems necessary and appropriate for my health and well-being.

I understand that the procedures used in the diagnosis and treatment of my condition has either been scientifically or empirically validated. The doctor will deliver treatment as is necessary for my particular-condition.

I am also,

informed and I understand that in the practice of Chiropractic and or natural medicine/nutrition there are some risks to treatment including but not limited to, fractures, disc injury, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain all potential risks and complications.

I wish to rely upon the doctor's judgment of what diagnostic tests and treatment modalities would be best assist me in my recovery.

I also acknowledge my right to ask questions regarding my condition, seek a second opinion and /or be informed of risks and benefits as far as they are known.

I have read or have read to me, the above consent. I have also had an opportunity to ask questions about its content. By signing below, I agree to the above-mentioned precepts. My informed consent will cover present and future conditions for which I may consult my doctor.

_____
Printed Name

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Date

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