

Disclosure & Consent for Chiropractic Adjustments and Care

To the Patient: You have a right to be informed about your condition and the recommended chiropractic adjustments and the other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks hazards inherent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy, massage therapy, and diagnostic x-rays, on me or (the patient named below whom I am legally responsible for) by the Chiropractic Doctor of Synergy Sports Therapy.

I have had the opportunity to discuss with the doctor of Chiropractic, my diagnosis, the nature and purpose of the Chiropractic adjustments and other procedures.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and possible increase symptoms or pain. 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 judgment during the course of the procedure which the Doctor feels at the time, based on the facts known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

To be completed by the patient representative, if the patient is a minor or physically or legally impaired.

Print Name

Print Name of Patient

Signature of Patient

Signature of Patient Representative

Date

Date