Arlington Family Chiropractic Clinic, LLC

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on my minor child by the licensed doctors of chiropractic, medical doctors and /or licensed physical therapist, who may be employed or engaged in practice at this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures, chiropractic treatment (manipulation/adjustment) or medical procedure. I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risk and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely but not limited to, fractures, disc injuries, strokes, and strains/sprains. I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

***Female patients: By my signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period:_____.*

Patient's Name (Print)_____

Signature: _____

Relationship (if not signed by patient):_____

Witness:_____ Date:_____