485 E. 17th Street, Suite 510
Costa Mesa, CA 92627
949.642.5660
drshannon@uppercervicalcareofsocal.com
www.uppercervicalcareofsocal.com

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including diagnostic X-rays on me, by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of the chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic, there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. Since I do not expect the doctor to anticipate and explain all risks and complications, I wish to rely on the doctor to exercise judgment during the course of the procedure and proceed with whatever he feels is in my best interest.

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

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

THANK YOU FOR COMPLETING THIS FORM
PLEASE EMAIL OR BRING WITH YOU ON YOUR FIRST VISIT