Tuttle Chiropractic Center, P.S.

Informed Consent

I understand that my doctor's recommendations are paramount for my optimum health and improvement of my condition. Failure to follow my doctor's recommendations may hinder or slow my recovery and increase the number of visits required to correct my problem.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by any licensed doctor of chiropractic who treats me at Tuttle Chiropractic Center, P.S.

I have had an opportunity to discuss with my doctor at Tuttle Chiropractic Center, P.S. and/ or other office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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

Patient Name:_____

Signature:_____

Date Signed:___/___/___ Witness to Patient's Signature:_____

If a Patient is a Minor, Physically, or Legally Incapacitated to be completed by Patient's Representative

Patient's Name:_____ Name of Representative:_____

Date Signed____/____/____ Signature of Representative:_____

Relationship or Authority of Patient's Representative:_____