INFORMED CONSENT
TO CHIROPRACTIC CARE

I hereby consent and request the performance of chiropractic procedures, including adjustments, examination tests, diagnostic x-rays, physiotherapy, and nutritional supplements for the purpose of treatment, on me or for whom I am legally responsible, by the physicians at Optimal Wellness and Chiropractic. ____

I have been informed that chiropractic is generally safe methods of treatment, but that, as with any health care procedure, there may be certain complications or side effects. Side effects include soreness, bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains. ____

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. ____

Standard Publicity Release Agreement

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treat-ment and publicity release agreement. I have been told about the risks and benefits of chiropractic and other procedures, and have had an opportunity to ask questions. 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.

_____

_____ _____

Printed Name of Patient Date

_____

Signature of Patient, Parent, or Guardian

Optimal Wellness and Chiropractic

"Do you want to live or LIVE WELL"