McMurtrey Chiropractic
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INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

Doctor/ Office Personnel	Patient	
☐	☐	I have been informed that it is not uncommon that patients have some discomfort after treatment. If any tests were performed outside this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the test results at my next scheduled appointment.
☐	☐	I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and necessary diagnostic radiographs , 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 listed below and or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.
☐	☐	I understand and am informed that in all healthcare including the practice of chiropractic there are some slight risks to treatment, including but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of my treatment, to my best interest.
☐	☐	I have read the above consent with the doctor or other office personnel, as indicated by our initials. I have also had and opportunity to ask questions about its consent and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

To be completed by the patient:

Print Patient Name **Signature of Patient** **Date**

Print Doctors/ Office Personnel Name **Signature of Doctor/ Office Personnel** **Date**