INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

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 chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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, and I wish to rely on the doctor to exercise judgement during the course 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:

_____
Print Name of Patient

_____
Signature of Patient

_____
Date Signed

To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

As: _____
Relationship or Authority of Patient's Representative

_____
Date Signed

Name and address of clinic/office:

LIFESTYLE CHIROPRACTIC
417 Front Street
Danville, CA 94526

Names of doctors treating this patient:

Mark H. Sembrat, D. C.

Witness to Patient's Signature_____Date _____

Translated by: _____Date _____