INFORMED CONSENT TO CHIROPRACTIC CARE

ADIO CHIROPRACTIC
RYAN DALZELL, DC
321-426-0446

Please discuss any questions or concerns with the Doctor before signing this consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various models of physical therapy and diagnostic X-rays by the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the Doctor the purpose and the benefits of chiropractic adjustments and other treatments. Alternatives to treatment have been reviewed. I understand that the Doctor named above does not treat specific conditions, but rather corrects vertebral subluxations and realigns the spinal column.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include but are not limited to fractures, dislocations, disc injuries, sprains/strains, and altered blood flow to the head/brain.

I understand that chiropractic and that reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

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Please print name of Patient

X_____

Signature of Patient Date

_____

Doctor's Signature Date

ADIO CHIROPRACTIC