

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I HEREBY REQUEST AND CONSENT TO THE PERFORMANCE OF CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC PROCEDURES, INCLUDING VARIOUS MODES OF PHYSICAL THERAPY, PHYSIOTHERAPY MODALITIES, THERAPEUTIC MASSAGE, NUTRITIONAL/DIET COUNSELING AND DIAGNOSTIC X-RAYS, ON ME (OR ON THE PATIENT NAMED BELOW, FOR WHOM I AM LEGALLY RESPONSIBLE) BY MCFARLAND CHIROPRACTIC GROUP, INC.

I UNDERSTAND 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. I WISH TO RELY ON THE DOCTOR TO EXERCISE JUDGEMENT DURING THE COURSE OF THE PROCEDURE IN WHICH THE DOCTOR FEELS AT THE TIME, BASED ON THE FACTS THEN KNOWN, IS IN MY BEST INTEREST.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE CONSENT. 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.

PATIENT'S NAME (PLEASE PRINT)

DATE

SIGNATURE OF PATIENT (OR GUARDIAN IF PATIENT IS A MINOR)

(PLEASE COMPLETE THE INFORMATION ON THE BOTTOM OF THIS FORM IF THE PATIENT IS A MINOR)

CONSENT TO TREATMENT OF A MINOR

NAME OF RESPONSIBLE PARTY: _____

SOCIAL SECURITY #: _____

RELATIONSHIP TO MINOR: FATHER _____ MOTHER _____ OTHER _____

ADDRESS OF RESPONSIBLE PARTY: _____

HOME PHONE: _____ BUSINESS PHONE: _____

RESPONSIBLE PARTY EMPLOYED BY: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ ZIP: _____

I (WE) BEING THE PATIENT OR GUARDIAN OF _____,
A MINOR, THE AGE OF _____ DO HEREBY CONSENT, AUTHORIZE AND
REQUEST **MCFARLAND CHIROPRACTIC GROUP, INC.** TO ADMINISTER SUCH TREATMENT
DEEMED ADVISABLE, NECESSARY OR REQUESTED ON THE ABOVE MINOR. I (WE)
AGREE TO HOLD **MCFARLAND CHIROPRACTIC GROUP, INC.** FREE AND HARMLESS FROM
ANY CLAIMS, SUITS FOR DAMAGES OR COMPLICATIONS WHICH MAY RESULT FOR
SUCH TREATMENTS.

DATE _____ SIGNED _____
(PATIENT/GUARDIAN)

DATE _____ SIGNED _____
(WITNESS)