LHC#: _____

INFORMED CONSENT TO CHIROPRACTIC CARE

LIVING HEALTH CHIROPRACTIC, PLLC
91 Troy Road – East Greenbush, NY 12061
Telephone: (518) 477-6330, Fax: (518) 477-5085

Patient Name _____ DOB _____

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 modes of physical therapy and diagnostic x-rays by the doctor of chiropractic noted above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

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, disc injuries, strokes, dislocations and sprains.

I understand that I will/may be receiving the following treatment:

- ❑ Chiropractic Adjustment
- ❑ Heat / Cold
- ❑ E-Stim
- ❑ Stretches
- ❑ Decompression Therapy / Traction
- ❑ Ultrasound
- ❑ Massage
- ❑ Other _____

I understand that chiropractic is not an exact science and that, therefore, 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.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Witness Signature _____ Date _____

Doctor's Signature _____ Date _____