INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including but not limited to, recommended food supplements, physiotherapy, rehabilitation, movement therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic or professionals named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working for 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 office personnel the nature and purpose of the 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 the complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Complete Agreement
I understand that this Agreement constitutes the complete agreement and understanding between Patient and Office and will not be changed or modified in any way unless agreed to by both parties in writing. I have read, or have had read to me, the above consent. I have had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures and policies. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

PLEASE READ THIS DOCUMENT CAREFULLY!! PLEASE DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ IT COMPLETELY.

THE PATIENT HAS FULLY READ THIS AGREEMENT AND UNDERSTANDS AND AGREES TO ABIDE BY ALL OF ITS TERMS.

To be completed by patient

_____
Print patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by patient's representative, if necessary, e.g., if the patient is a minor or is Physically or mentally incapable:

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

As: _____
Relationship or Authority of patient's Representatvie

_____
Date Signed

To be completed by doctor or staff

Name and address of clinic

CENTER FOR NECK AND BACK PAIN
3011 Citrus Circle Suite 102
Walnut Creek, CA 94598

Treating doctor(s) and personnel

DOUGLAS HERTING D.C.

_____ _____
Witness to patient's Signature Date

_____ _____
Translated by: Date