

Mason Family Chiropractic
Dr. Marie S. Mason
154 West Main Street, Suite 1
Bridgeport, WV 26330

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 physical therapy and diagnostic x-rays, on me (or the patient named below for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, associated with, or serving back-up for the doctor of chiropractic named below, including those working at the clinic or office listed above or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named above and or with other office or clinic personnel, the nature and the 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, dislocation 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, 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(s) for which I seek treatment.

Patient's Name

Patient's Signature (parent or legal guardian if minor)

Date Signed

Witness