

CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I (we) hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____, by Dr. Gaudreau D.C. and/or licensed doctors of chiropractic who may be employed or engaged in practice in the Griswold Chiropractic Clinic.

I have had an opportunity to discuss with Dr. Gaudreau D.C. or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgements based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgement during the course of the procedure which he/she feels in the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complication associated with chiropractic services is very low, anyone undergoing adjustment or manipulative procedures should know the possible hazards and complications which may be encountered or result. These include, but are not limited to fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its content and by signing below agree to the named procedures.

Witnesses:

Patient's Name

Patient's Signature

Date: _____

Relationship or authority if not signed by patient

Doctor's Notes

Patient counseled by the use of the following:

_____ Discussion

_____ Other (please specify)
