

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 below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, 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 doctor of chiropractic named below and/or with other office or clinic personnel the nature and 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 in 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, 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 interest.

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, I agree to the above-named procedures. 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.

To be completed by patient or patient's representative, if necessary (e.g., if patient is a minor or is physically or mentally incapacitated):

Print Patient's Name

Print Name of Patient's Representative

Signature of Patient

Signature of Patient's Representative

Date Signed

As: _____
Relationship or Authority of Patient's Rep.

KAPSNER CHIROPRACTIC CENTERS

To be completed by doctor or staff:

Name and address of clinic (Please check one):

3005 S. Lamar, Ste D-112

8440 Burnet Rd., Ste 118

2000 S. IH 35 Ste K5

Name of Doctor treating this patient

Michael Kapsner, D.C.

William Maples, D.C.

Michael Snow, D.C.

James Schiffer, D.C.

Witness to Patient Signature

Date

Translated By

Date