

## INFORMED CONSENT TO CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by **Nathan R. Falk, D.C.** and/or other licensed doctors of chiropractic who now or in the future work at Chanute Chiropractic Center.

I have had the opportunity to discuss with Nathan R. Falk, D.C. 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 further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely in the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, 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 and for any future conditions for which I seek treatment.

TO BE COMPLETED BY THE PATIENT:

\_\_\_\_\_  
PRINT PATIENT'S NAME

\_\_\_\_\_  
SIGNATURE OF PATIENT  
(OR PARENT/GUARDIAN)

DATE SIGNED: \_\_\_\_\_