

Virginia Family Chiropractic & P.T., PLLC

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient in this office, hereby authorize Virginia Family Chiropractic & P.T. to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of finding during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic treatment, the reason why the above named treatment is considered necessary, the benefits, the risks and the side effects of the treatment and consequences of not having the proposed treatment or possible alternative modes (referrals) of treatment, which were explained to me by Virginia Family Chiropractic & P.T.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited, to muscle strains and sprains, fractures, dislocations, disc injuries and strokes. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatments which he feels at the time, based upon the facts then known, is in my best interest.

My doctor has responded to all of my requests for information about proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to treatment. I also certify that no guarantee of assurance has been made as to the results that may be obtained.

Date: _____ Name: _____

Signature: _____

Witness: _____ or Nearest Relative: _____