RC Chiropractic, LLC
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Patient Treatment Consent

I hereby request and consent to the performance of Chiropractic adjustments and other chiropractic procedures, including modes of physical therapy diagnostics x-ray, on me (or the patient names below for whom I am legally responsible) by the doctor chiropractic named below or other licensed doctors who now or in the future work at this clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that, as is in the practice of medicine, in the practice of chiropractic there are some reason to including but not united 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 upon the doctor to exercise judgment during the course of the procedure physical feels at the time, based upon the facts than known to him or her 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 consent and signing below 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 condition(s) for which I seek treatment.

Patient Name (PRINT): ________________________________ Date: _________________

Patient Signature: ____