CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physio-therapy. And diagnostic x-rays, on me (or on 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 a 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 other office or clinic personnel the nature and purpose of Chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to 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 interests.

Oxmoor Chiropractic
Taylor Flannagan, D.C.
1021 Oxmoor Chiropractic
Homewood Al 35209

TO BE COMPLETED BY PATIENT OR REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED.

PATIENT'S NAME_____ SIGNATURE OF PATIENT_____

DATE SIGNED _____ SIGNATURE REPRESENTATIVE_____

RELATIONSHIP or AUTHORITY OF PATIENT'S REPRESENTATIVE _____

TRANSLATED by _____ DATE _____