

ALDEN CHIROPRACTIC, INC.
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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 for whom I am legally responsible) by the doctors of chiropractic named above, or any others working at this office.

I understand and I 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. I wish to rely on the doctor to exercise such judgement during the course of the procedure which the doctor feels at the time, based on 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 the opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment of my present condition and for my future condition(s) for which I seek treatment.

Signature

Date

Print Name

Signature of Witness

If you are signing as legal representative for the patient:

Print name of Patient

Relationship giving signer authority