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 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 associate with or serving as 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 with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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, and is in my best interests.

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 condition(s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patients

_____
Date signed

To be completed by patients representative, if necessary, e.g. if patient is a minor or physically or legally incapacitated:

_____
Print Name of Patient

_____
Print Name of Patients Representative

_____
Signature of Patient's Representative

_____
As:
Relationship or authority of Patient's Representative

_____
Date Signed

To be completed by doctor or staff.

Name and address of clinic/office:

MOYLAN CHIROPRACTIC
1675 MORENA BLVD STE 205
SAN DIEGO CA 92110-3703
(619) 276-5752

Print name(s) of doctor(s) treating this patient:

JEROME P. MOYLAN, D.C.

Witness to Patients Signature: _____ (Date)

Translated by: _____ (Date)

The **signed original** is to be filed in patient's file and a copy is to be given to the patient