CATER CHIROPRACTIC CLINIC

INFORMED CONSENT FORM

I herby request and consent to the performance of chiropractic treatments and other chiropractic / medical procedures, including various forms of physio and physical therapy and x-rays by Cater Chiropractic Clinic, PC**.** This consent is extended to other licensed chiropractors, chiropractic assistants and/or licensed massage therapists, who are now or in the future employed by working with or associated with this office.

I certify that I have had the opportunity to discuss with the doctor of chiropractic and/or other office personnel the nature and purpose of the care that is being provided. I understand that results are not guaranteed. Further, I have been informed and understand that in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor who has explained all of these things to me is not expected to be able to anticipate and explain all the possible risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care based on the facts known at the time and what is in my best interest.

My signature below certifies that I have read or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and treatment options have been explained. By signing this consent form I agree to the care being provided to me for the entire course of treatment for my present condition(s) or for any future condition(s) for which I seek treatment.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date
_____	_____	_____
Patient's guardian or parent	Signature	Date

*****Females Only***Pregnancy Release*****

This is to certify that to the best of my knowledge I am not pregnant and the doctor has my permission to perform any necessary X-rays. If there is any possibility you may be pregnant at this time, do not sign below and inform the doctor or staff.

_____

Patient Signature