INFORMED CONSENT TO CHIROPRACTIC CARE

Douglas P. Lichtinger, D.C.
212 High Street
P. O. Box 239
Waterford, PA 16441
(814) 796-9161

Patient Name:_____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of Physical Therapy by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office personnel the purpose and benefits of the chiropractic adjustments and treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause problems, I understand there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, stroke, dislocations and sprains.

I understand I will be receiving the following treatment:

Spinal Manipulation and/or therapy

I understand chiropractic is not an exact science and, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction; I consent to the proposed treatment.

_____ _____

Signature of Patient, Parent, Guardian or Personal Rep. Date

_____ _____

Print name of person signed above Relationship to Patient