Active Care Chiropractic

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures including examination tests, sports/DMV physicals and various modes of physical therapy, on me (or the patient named below for whom I am legally responsible) by Sara L. Griffin, D.C., Active Care Chiropractic and other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for Sara L Griffin, D.C. and Active Care Chiropractic.

I understand that, as with any health care procedure, there are certain complications which may arise during chiropractic adjustments. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with Sara L Griffin, D.C. and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or had read to me the above explanation of the chiropractic adjustments and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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: (Parent or guardian if patient is a minor, or physically or legally incapacitated)

____
Printed Name of Patient

______________________________________ ______________
Signature of Patient or Parent/Guardian Date

____
Relationship to Patient

Sara L Griffin, D.C.
(Printed Name of Doctor Treating Patient)

Active Care Chiropractic
14156 Amargosa Rd. Ste G
Victorville, Ca. 92392

To be completed by doctor or staff:

______________________________________ ______________
Witness to Patient's Signature Date

______________________________________ ______________
Translated By Date