**Tumwater Chiropractic Center, PLLC**
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# INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS & CARE

In the process of determining the need for chiropractic services, certain examination procedures may be employed to assist the doctor of chiropractic associated with this clinic, in making recommendations regarding diagnosis and treatment.

I understand and am informed that, Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise their patients with spinal problems, that there are some very slight risks to treatment, including, but not limited to, fractures, muscle strains and sprains, strokes and disc injuries. I do not expect the doctor to be able to anticipate and explain all risks and complications, and 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, is in my best interests.

I understand that I have the opportunity to discuss with the doctor of chiropractic, the nature and purpose of chiropractic adjustments, examination procedures and the possible outcomes of treatments. Also, I have the opportunity to discuss with the doctor, alternative treatments for my condition.

Chiropractic is considered to be one of the safest, most effective forms of therapy for spinal problems and I accept the risks.

I hereby request and consent to the performance of chiropractic examination, adjustments and other chiropractic procedures.

I have read, or have had read to me, the above consent. By signing below, I agree to the above-named procedures. I intend this 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 the patient:

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PRINT PATIENT'S NAME          SIGNATURE OF PATIENT/GUARDIAN          DATE SIGNED

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**DOCTOR'S SIGNATURE**