Highland Chiropractic Clinic, Inc.

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DISCLOSURE AND CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedures after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to inform you so that you may give or withhold your consent on any recommended procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, homeopathic injections (cosmetic and/or analgesic) and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Larry Vance and Dr. Sam Adams and/or licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for one of the afore mentioned Dr(s). I have had the opportunity to discuss with the doctor or my diagnosis, the nature and purpose of the chiropractic adjustments and other procedures or alternatives I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, increased symptoms and pain or no improvement of symptoms and pain. 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 treatment, which the doctor feels at the time, based on the facts then known, to do what is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I also acknowledged that some of the treatment I may receive will be done in a public area of the office. If you are uncomfortable with other patient's viewing your adjustments, therapies or overhearing any part of your conversations with the doctor, you may request that said treatment be done in a private room.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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 the patient's representative or Legally responsible guardian:

_____	_____
Print name	Print patients name
_____	_____
Patient signature	Print name of patient's representative
_____	_____
Date Signed	Signature of patient's representative

To be completed by doctor or staff:

_____	_____
Witness to patient's signature	Date
_____	_____
Translated by (if applicable)	Date