JOHNSON CHIROPRACTIC

270 S. Collins Rd., Ste. 200 * Sunnyvale, Texas 75182
972) 226-4444 Phone * 972) 203-1914 Fax

CONSENT TO TREATMENT

PATIENT'S NAME:_____ DATE:_____

I hereby authorize the staff of Johnson Chiropractic to provide treatment for myself, including **CHIROPRACTIC ADJUSTMENTS, X-RAYS, DIAGNOSTIC TESTING, PHYSICAL THERAPY, NUTRIONAL THERAPY, REHABILITATION, MASSAGE THERAPY,** and other services as are deemed necessary. If the patient is a minor, I certify that I am the legal guardian and that I grant permission for care of the patient.

Signed:_____

Parent or Guardian:_____Relationship:_____

Witnessed by:_____

Translated by:_____

PREGNANCY RELEASE

I certify that I am not pregnant. I hereby release Johnson Chiropractic and its staff from any and all liability.

Signed:_____

Witnessed by:_____

Translated by:_____