## Informed Consent for Treatment of Care

I hereby request and consent to the performance of medical services, examinations, chiropractic adjustments and other procedures (including various modes of physical therapy and diagnostic x-ray), or physical therapy on me (or the patient named below, for whom I am legally responsible) by Cynthia Munson, D.C., and/or other licensed clinic doctors who now or in the future treat me while employed by, are working or associated with, or serving as a back-up doctor, including those working at the clinic. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of medical services and examinations, chiropractic adjustments, and other procedures. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I also understand my responsibility to inform this office of any changes in my medical status.

I have read or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entirety of my treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature_______________________________________________Date:_______________

Consent to treat a Minor____________________________________________Date:_______________

Guardian or Spouse's
Signature of Authorizing Care_________________________________________Date:_______________