INFORMED CONSENT TO CHIROPRACTIC CARE

Shannon Wyman, D.C. / Warren Moore, D.C. / Aaron Shoemaker, D.C.

Spaulding Chiropractic Clinic, Inc
515 7th Ave., Ste 230
Fairbanks, AK 99701

Telephone : (907) 456-4234

Patient Name _____ Birthdate _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Please discuss any questions or concerns with the Doctor.

Signature of Patient or Patient Representative_____

Witness Signature_____Date_____

Doctor's Signature_____ Date_____