



INFORMED CONSENT TO CHIROPRACTIC SPINAL MANIPULATION, SUPPORTIVE CARE AND CONSENT FOR TREATMENT

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, on me(or on the patient named below, for whom I am legally responsible)by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by , working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risk to treatment, including, but not limited to : fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns.

I understand and comprehend all such risks and complications. I , by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed by my doctor to be in my best interest.

I have read, or have had read to me, the above consent. I have also had and 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 entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

To be completed by patient's representative, if necessary,e.g., if patient is a minor or physically or legally incapacitated:

Print Patient's Name

Print Patient's Name

Signature of Patient

Print Name of Patient's Representative

As:

Relationship or Authority of Patient's Rep.

Date Signed

Date Signed

To be completed by doctor staff:

Name and address of clinic/office:

Print name(s) of doctor(s) treating this patient:

Hoffman Chiropractic
8727 Shoal Creek Blvd
Austin, TX 78757

Robert B. Hoffman D.C.
Myra Hoffman D.C.

Witness to Patient's Signature: _____