



Hoffman Chiropractic  
 8731 Shoal Creek Blvd  
 Austin, TX 78757  
 (512) 346-5164

## 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 is 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 in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for 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

\_\_\_\_\_  
 Print Name of Patient's Representative  
 As:  
 Relationship or Authority of Patient's Rep.

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Signature of Patient's Representative

\_\_\_\_\_  
 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:

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

Witness to Patient's Signature: \_\_\_\_\_ Date Signed \_\_\_\_\_