WELLNESS CONCEPTS OF FLORIDA
CONSENT TO CHIROPRACTIC SERVICES

CONSENT TO CHIROPRACTIC SERVICES Pt. Initials __________

I hereby request and consent to chiropractic manipulation, neuromuscular therapy, exercise, and other procedures including various modes of physiotherapy, diagnostics, diagnostic x-rays, and/or tests by Wellness Concepts of Florida and their staff who now or in the future will treat me (or on the patient named below, for whom I am legally responsible) while employed by this office. I hereby authorize and provide full consent to Wellness Concepts of Florida to obtain any and verify any and all medical and insurance information which includes, but is not limited to diagnostic test results, patient files, X-rays, etc. from any health care provider.

I have had an opportunity to discuss with the physician and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and informed that, as in the practice of medicine, with the practice of chiropractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest.

I have read, or have had read to me, the full consent above and have had an opportunity to ask questions about its content, and that by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for the future conditions for which I seek treatment by this clinic and/or employed staff.

CONSENT TO TREATMENT OF A MINOR CHILD Pt. Initials __________

I authorize the licensed doctor to administer chiropractic care as deemed necessary to my (Relationship) __________________Name ____

SIGNED ____ Date _____________________

WITNESS ____ Date _____________________