INFORMED CONSENT FOR CHIROPRACTIC CARE

Provider: Dr. D. Jessica Crivelli

PLEASE ADDRESS YOUR QUESTIONS/CONCERNS WITH THE DOCTOR DURING THE VISIT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physio-therapy on me (or on the patent named below, for whom I am legally and financially responsible) by Dr. Jessica Crivelli of Spring Hill Chiropractic Clinic d/b/a Align Chiropractic Day Spa.

I have had the opportunity to discuss with the doctor and/or with office personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment may have also been reviewed.

Though chiropractic adjustments are usually beneficial and seldom cause any problems, I understand and am informed that there are risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains. ☐ (Please Initial)

I understand that I may be receiving one or more of the following treatments:

Chiropractic Manipulative Adjustments, Activator, Thompson Drop, Physio-therapies or modalities *(for which a $10.00 service fee may apply)*, Massage Therapy *(for which an additional fee may apply),* Spinal Rehabilitative Exercises, Vitamin, Mineral and Nutrient supplement suggestions. ☐ (Please Initial)

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 all been answered to my satisfaction and I am willingly providing my signature as consent to the proposed treatment.

Patient Signature Date

Parent /Legal Guardian Signature Date
(Must be signed by above for all minors)

Witness Signature Date

Doctor's Signature
Dr. D. Jessica Crivelli

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