Mar Chiropractic

Serving Animals & Humans in San Diego and the Valley of the Sun

Informed Consent for Chiropractic Treatment and Care

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, vital signs, examinations (physical, orthopedic and neurological), test results, range of motion and muscle strength testing, diagnose(s), treatments received, exercise rehabilitation/at-home recommendations and any plans for future care of treatment.

I hereby request and consent to the performance of chiropractic adjustments, physical examination, soft tissue procedures, physiotherapy and exercise rehabilitation/at-home recommendations if warranted should I elect to seek care from Dr. Mar in office. I consent to allow Dr. Mar to evaluate and treat me on an emergency care basis should I be in a condition where I am not able to authorize verbal consent.

I understand that, as in the practice of all healthcare, in the practice of chiropractic care there are some risks to treatment, including but not limited to, sprains, muscle soreness, disc irritation, dislocations, fractures and stroke in extremely rare cases. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Dr.'s attention it is your responsibility to inform the Doctor prior to examination and/or treatment.

I do not expect the Doctor to be able to anticipate and explain all risks and complications. I wish to rely on the Doctor to exercise judgement during the course of the procedure which the Doctor feels at the time, based on the facts then known, and are in my best interests.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the doctor(s) of Mar Chiropractic to perform such. 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.

_____

PATIENTS NAME (PLEASE PRINT)

_____

SIGNATURE

_____

DATE

_____

SIGNATURE OF PATIENT"S PARENT OF MINORS OR LEGAL REPRESENTATIVE