CONSENT TO CHIROPRACTIC SERVICES

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 a backup for the Doctors 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 scope of practice, nature and purpose of chiropractic care: specifically manual care; adjustments and other procedures. I understand that with manual care, i.e., adjustments, there is a certain risk of but not all inclusion of: muscle or ligament strains or sprains, bony fractures, cerebral vascular or neurological insult.

I understand and am informed as to the nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the below named Doctor of Chiropractic and/or his/her associates and assistants and do not expect the Doctor to be able to anticipate and explain all the risks and complications, and wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based upon the facts known, is in my best interests.

Krieger Chiropractic / William L. Krieger, DC

Name of Facility / Doctor of Chiropractic

I have read, or have been read to me, the above consent. I have also had the 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.

_____
Print Patient's Name

_____ Date _____
Signature of Patient

_____ Date _____
Witness / Relationship to Patient

THE FOLLOWING IS TO BE COMPLETED BY PATIENT'S REPRESENTATIVE, IF NECESSARY, e.g., IF THE PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED:

_____
Print Patient's Name

_____ Date _____
Signature of Patient's Representative

_____
Relationship or Authority of Patient's Representative