O'Malley Chiropractic Health Center, LLC
78 Beaver Rd. Suite 1A
Wethersfield, CT 06109
860.257.9400

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patients named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctor's 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 above, including those working as the clinic or office listed or any other office clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in practice of medicine, in 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 I 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 then known, is in my best interests.

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 this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

_____
Authorized Provider Signature

_____
Date Signed

To be completed by patient's representative, if necessary, e.g., if patient is a minor or is physically or mentally incapacitated:

_____
Print Patient's Name

_____
Print Name of Patient's Representative

_____
Signature or Patient's Representative

As:_____
Relationship or Authority of Patient's Rep.

_____
Date Signed