



Informed Consent to Chiropractic Care

Tara M. Gill, DC

Patient: Please discuss any questions or concerns with the Doctor *before* signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or on the patient named below, for whom I am legally responsible) by Dr. Tara Gill.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments. Alternative types of care have been reviewed.

Though chiropractic adjustments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to adjustments. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

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 adjustment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

This is considered my insurance verification signature on file. I give my permission to release any medical records to my insurance and any other medical providers.

Signature of Patient _____

Date _____

Print Patient Name _____

Date _____

Signature of Parent/Guardian _____
(If patient is a minor)

Date _____