Dr. Brett Smith D.C.
842 Washington St Suite B
San Diego, CA 92108

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 and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or her preceptor 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 back-up for the doctor of chiropractic named below, including those working at the clinic or office listed above or any other office clinic.I have had an opportunity to discuss, with the doctor named above and /or with other office or clinic personnel, the nature and purpose of the chiropractic adjustments and other procedures.Chiropractic treatment involves the science, philosophy and art of locating and connecting spinal misalignment and as such, is orientated toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his/her hands or mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click.” It is my intention to rely on the doctor to exercise professional judgment during the course of any procedure, which he/she feels at the time to be in my best interest. Neither the practice of the chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with like cases.

I understand and am informed that, as in the 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. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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 up the facts then known, is in my best interest.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for the future care or treatment. I understand that this information serves as a basis for any plans for the future care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third party payer can verify that services billed were actually provided.

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 intent 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.

Patient Signature	Date
Patient Name (printed)	Date

Doctors Treating This Patient:
Dr. Brett Smith

Name & Address of Office 842 Washington St. Suite B San Diego, CA 92108
Witness to Patient's Signature:
Translated by:

To be completed by patient's representative/parent or guardian:

Date:	
Patient's Name:	Patient's Representative:
Signature of Patient's Representative:	Relationship or Authority: