ACTION CHIROPRACTIC CENTER

INFORMED CONSENT

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 Ron D. Schmidt, D.C. or David J. Simpson, D.C.

I have had an opportunity to discuss with Dr. Schmidt and or Dr. Simpson the nature and purpose of his recommended care, including chiropractic adjustments and other procedures, and he has taken the time to answer all questions to my satisfaction. At no time has the Doctor made any guarantees or promises that he could improve or cure my condition.

I understand and am informed that, as in the practice of medicine there are some risks to chiropractic care, including but not limited to sprains and strains, dislocations, fractures, and disc injuries. Fractures are rare occurrences and generally result from some underlying weakness of the bone which the Doctors check for during the taking of your history and during examination and x-ray. Some patients may feel some stiffness and soreness following the first few days of treatment. 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 doctors' attention, it is your responsibility to inform him.

_____

Patient's and Patient's Representative's Name Date

_____

Patient's or Patient's Representative's Signature

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