REGIONAL CHIROPRACTIC CENTER
LAKE NORMAN
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INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.
I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here, _____ and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with _____ 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 the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interest at the time, based upon the facts then known.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Massage Therapy:

I understand myofascial release/bodywork may be contraindicated. I also understand that bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a Physician, Chiropractor or other qualified medical specialist for any mental or physical ailment that is beyond the scope of practice of my massage therapist. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness. Because myofascial release/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand there should be no liability on the part of the therapist should I forget to do so. It is also my understanding that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the scheduled appointment. I understand I will be charged for appointments I cancel or miss without 24 hours notice of my scheduled appointment. I also understand that if I arrive late I will receive the remainder if the time scheduled, but will be liable for payment in full.

_____ _____
Patient's Name **Print name of Patient (If minor)**

_____ _____
Signature **Signature of Parent or Guardian**

Doctor Signature:_____