



TOLMAN CHIROPRACTIC

Disclosure and Consent Form

To Our Patient: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments as well as other procedures that may be performed during the exam or with care you receive in our office. This information is so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is simply an effort to make you better informed so you may give or withhold your consent for treatment.*

I hereby request and consent to the performance of examination, chiropractic adjustment and other procedures, including various modes of physical therapy and/or diagnostic tests including x-rays, on me (or the patient named below, for whom I am legally responsible) by Brian Tolman DC, and/or other licensed doctors of chiropractic or those working at the clinic who now or in the future treat me while employed by, working with, or serving as a backup for Dr. Tolman. I understand I will have the opportunity to discuss with Dr. Tolman, or anyone whom may be assisting or replacing Dr. Tolman, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to examination and treatment including, but not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious side effects are rare but will be made known at my request. 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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the recommended treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend 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.

To be completed by the patient:

OR

To be completed by the patient's representative, if necessary, for example, if the patient is a minor or physically or legally incapacitated:

Print Name

Print Name of Patient

Signature of Patient

Print Name of Patient's Representative

Date Signed

Signature of Patient's Representative

As: _____

Relationship to patient

Date Signed