

San Diego Spine & Rehab Inc.
Informed Consent

I hereby request and consent to the performance of procedures, which may include but is not limited to various modes of physical therapy, diagnostic x-rays, medical doctor, and/or chiropractic adjustments on me (or the patient named below, for whom I am legally responsible) by the doctor named below and/or other licensed doctors who now or in the future treat me while employed by, work or associated with or serving as back up for San Diego Spine Rehab Inc., including those working at the center or office listed below or any other office or center.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures.

I understand and am informed that in the practice of medicine and in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disk injuries, strokes, and dislocations and sprains. I do not expect the doctor to be able to anticipate and end 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 upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedure. 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 PATIENT

Patient's Name: _____ Signature of Patient _____

Date Signed: _____ Signature of Representative: _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name: _____ Signature of Patient _____

Date Signed: _____ Signature of Representative: _____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office: _____

Address: _____

Name of Doctor's treating this patient:

1. _____ PIN# _____

2. _____ PIN# _____

3. _____ PIN# _____