SPRING GROVE
PHYSICAL MEDICINE
& REHABILITATION

INFORMED CONSENT FOR CHIROPRACTIC, MEDICAL, AND/OR PHYSICAL THERAPY TREATMENT AND CARE

I hereby consent to the performance of the medical treatment and therapy I will be receiving that may include, but not limited to, chiropractic adjustments, modalities, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient listed below, for whom I am legally responsible). These treatments may be performed by a licensed doctor of chiropractic, medical physician, licensed physical therapist/physical therapy assistant, massage therapist, and/or chiropractic assistant who now or in the future treat me while employed by, working, or associated with or serving as back-up for the providers named below, including those working at the clinic or office listed below.

I have had an opportunity to discuss with Spring Grove Physical Medicine and Rehabilitation, Ltd. / Spring Grove Medical Offices, Ltd. and/or any other office or clinical personnel the nature and the purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy there are some risks to treatment including, but not limited to fractures, disc injuries, strokes, dislocations, and sprains. 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 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 procedures. 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.

Patient's Name:_____

Patient's Signature: _____ Date: _____

Witness to Signature: _____ Date: _____

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

Signature of Representative:
_____Date:_____

Relationship: _____

Witness to Signature: _____Date: _____