Robertson Spinal Rehab Associates

Out of injury, back to life

Informed Consent to CHIROPRACTIC CARE/THERAPY

- I have been informed that it is not uncommon that patients have some increased discomfort after care. If that happens, I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms, I can call the number below.

- If any tests were performed outside this office (laboratory or other diagnostic procedures), I understand that the doctor will notify me of the results at my next appointment.

- I hereby request and consent to the performance of chiropractic manipulative therapy and other chiropractic procedures, including various modes of physiotherapy / physical rehabilitation and, if necessary, diagnostic x-rays on me as prescribed by the Doctor of Chiropractic named below and/or anyone working in this clinic is authorized by the Doctor of Chiropractic listed below.

- I have had the opportunity to discuss with the Doctor of Chiropractic named below 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 further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to: muscle strains and sprains, disc injuries, and strokes. 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 procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

- I have read the above consent form, with the doctor, as indicated by our signatures. I have also had an 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 further conditions for which I seek treatment.

To be completed by the patient:

_____	_____	_____
Patient's Printed Name	**Signature of Patient** (parent/guardian)	**Date Signed**

_____	_____
Dr. Julia R. Robertson D.C.	Witness

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