Nelson & Nelson CHIROPRACTIC
1660 S. Horner Blvd.
Sanford, NC 27330

Informed Consent
Diagnostic X-Rays, Chiropractic Spinal Adjustments and Physiotherapy

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various therapy modalities (including but not limited to ultrasound, muscle stimulation, interferential, ice, heat, traction) and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by the licensed doctors of Garry Nelson, DP PC including any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that some spinal manipulations involve the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: **fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns**. I understand and comprehend all such risks and complications and realize that alternatives to care might include medical treatment, surgery or doing nothing. By my signature below, I confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor of chiropractic to be in my best interest.

A patient's written consent need only be obtained on time for all subsequent care given to the patient in this office.

I have read, or have had read to me the above informed consent. I have had an opportunity to ask any and all questions about its content and by signing below, I agree to the aforementioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

Patient Signature: _____ Date: _____

Printed Name: _____

Consent to Treatment of a Minor Child

I hereby authorize the doctors Nelson Chiropractic Center, and/or whomever they may designate as assistants, to administer treatment as deemed necessary to

Signature of Parent or Guardian: _____ Date: _____

Relationship: _____

Chiropractic Assistant Witness Signature: _____