Larson Chiropractic, P.C.
676 Mullins Colony Drive
Evans, GA 30809

INFORMED CONSENT TO CHIROPRACTIC CARE
Dr. Eric Larson

I hereby request and consent to the performance of chiropractic adjustments and other associated procedures, including various modes of therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by one of the doctors named above. I have had the opportunity to discuss with the doctor and /or with other clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed. Though chiropractic adjustments are usually beneficial and seldom cause any problems, I understand and am informed that there are potential risks to treatment. Risks include, but are not limited to: fracture, disc injuries, strokes, dislocations and sprains.

I understand that I may receive the following treatment:

- Examination
- X-rays
- Therapy
- Chiropractic Adjustments

I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ Date_____

Signature of Parent_____ Date_____
(If Patient is a minor)

Female Patient Pregnancy Disclaimer

This certifies that I understand the potential necessity of having x-rays taken and grant permission for the procedure. In doing so, I release the doctor/clinic from responsibility for potential damage arising from the procedure. At the present time: I am pregnant ___ I am not pregnant ___.

Signature of Patient_____ Date_____