Larson Chiropractic, P.C. - Evans, GA
Larson Chiropractic Wellness Center, P.C. – Eatonton, GA

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 the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those working at the clinics or offices listed above or any other office or clinic.

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.

I understand that I may receive the following treatment:

*Examination *X-rays *Therapies *Chiropractic Adjustments

I understand and I 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 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 treatment which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read, and/or have had read to me, the above consent. 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 future condition(s) for which I seek treatment. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I consent to the proposed treatment.

Print Patient Name_____ Date_____

Signature of Patient/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_____