

**CONSENT TO TREAT**

PATIENT'S NAME: \_\_\_\_\_

I have been informed of the nature of my disorder(s) and the nature and purpose of chiropractic procedures proposed as treatment. I have also been informed of the possible consequences and risks inherent in such treatment. The availability of alternative treatment options has been explained to me. I have also been advised of the possible consequences if I decide not to receive care. I understand there is no guarantee for any specific cure or result.

I HAVE READ THE ABOVE PARAGRAPH AND UNDERSTAND THE INFORMATION PROVIDED. THIS INFORMATION HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS, WHICH I HAVE ASKED, HAVE BEEN ANSWERED TO MY SATISFACTION.

I THEREFORE AUTHORIZE BURDEN CHIROPRACTIC & WELLNESS TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DOCTOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

When the patient is a minor or unable to consent:

Patient is a minor \_\_\_\_\_ years of age

Patient's name: \_\_\_\_\_

Person legally authorized to sign for patient – please print name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature of authorized person: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's signature: \_\_\_\_\_ Date: \_\_\_\_\_