INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination test, and physical therapy techniques, for me (or the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment, including but not limited to: muscle sprains and strains, disc injuries, dislocations, broken bones and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based on the facts then known, are in my best interest. I understand that chiropractic treatments are generally considered safe and effective.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose, and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

Timothy P. Angelo, D.C. C.C.E.P.
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DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

______________________________	______________
Signature of Patient	**Date**
Printed Name of Patient	**Date**
Signature of Patient's Guardian or Representative (If patient is a minor or incapacitated)	**Date**
Authorized Facility Signature	**Date**
Translator (if translation required)	**Date**