HANDS ON HEALTH CARE

1165 Garfield Street

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INFORMED CONSENT TO TREAT

I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and soft tissue techniques, on me (or the patient named below, for whom I am legally responsible) by John K. LeGat, D.C. and/or other licensed doctors of chiropractic who now or in the future work for Hands on Health Care.

I have had an opportunity to discuss with the doctor of chiropractic named and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks of 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 the risks and/or complications, and I wish to reply upon doctor to exercise judgment during the course of the procedure which the doctor feels at the times, based upon the facts then known to him or her, is in my best interest.

I have read, or have had it read to me, the above statement. I have also had an opportunity to ask questions about this 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 conditions and for the future condition(s) for which I seek treatment.

Patient Signature _____ Date _____

Witness Signature _____ Date _____