

**First Choice Chiropractic**

**CONSENT TO TREAT**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Chart# \_\_\_\_\_

A patient coming to the doctor gives the doctor permission and authority to care for the patient in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problems. In rare cases underlying physical defects, deformities, or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known or to learn through health care procedures, from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

**I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed in my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize a Doctor of First Choice Chiropractic to treat me.**

**I have read and understand the foregoing.**

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Please inform the receptionist if the patient is under the age of 18: a parent or guardian must sign a consent to treat a minor form.

(Authorization expires three years from date above)