Naples
Chiropractic
Associates

9955 Tamiami Trl N, Ste 1 Naples Fl 34108

Patient Informed Consent

I _____, the undersigned, consent to care at this clinic. I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this states statutes. I understand that I have the opportunity to discuss with the doctor and/or with other office personnel, the nature and purpose of chiropractic adjustments. I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patients above, for whom I am legally responsible) by the doctor of chiropractic and support team. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include but are not limited to : aggravating and/or temporary increase in symptoms muscle spasms, 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's judgement, based upon the facts then known, is in my best interests. I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures.
I have had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures.

Patient or Parent/Guardian Signature

_____

Date_____

Doctors Signature

_____

Date_____