

LAKESIDE CHIROPRACTIC

Consent to Chiropractic Treatment

I authorize the performance of examination, x-ray (when needed) and chiropractic treatment to be performed by, or under the direction of, Dr. Cindy M. Pradhan and/or such doctors/paraprofessionals/assistants as may be selected by the doctor to perform such professional procedures, as she deems necessary.

I recognize that during the course of procedure, unforeseen conditions may necessitate additional or different procedures/services than those set forth above and I further authorize and request Dr. Cindy M. Pradhan to perform such procedures as are in her professional judgment necessary and desirable.

The nature, purpose and possible consequences of the procedures, possible alternative methods or treatment, the risk involved and the possibility of complications have been fully explained to me by my attending doctor of chiropractic.

No guarantees or assurances have been made or given by anyone as to the specific results that may be obtained and none are promised.

I, the undersigned, have read and understand the contents of this authorization.

Patient or authorized person signature_____

Relationship (if other than patient)_____

Witness_____

Date_____