MILLER WHITMER
FAMILY CHIROPRACTIC

CONSENT TO CHIROPRACTIC TREATMENT

Patient: Please discuss any questions or concerns with the Doctor **before** signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Miller-Whitmer Family Chiropractic and Wellness Center, Inc., and Doctors (Miller and Whitmer).

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the Chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed,

I understand that I will be receiving the following treatments and associated risks.

1. Chiropractic Adjustments-fracture, stroke
2. Ultrasound- periosteal burns
3. Interferential – spread precancerous cells
4. Intersegmental Traction- aggravate pre-existing conditions
5. Myofascial Release- no associated risk
6. Neuromuscular Reeducation – strain/sprain

Signature of Patient: _____

Signature of Parent/Guardian (if minor) _____

Doctor's Signature: _____

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