INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Charlotte D. Burgess and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working for, associated with, or serving as back-up for Dr. Charlotte Burgess, including those working at Burgess Chiropractic, PA or any other office or clinic.

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

I understand that, as in the practice of medicine, the practice of chiropractic there are some risks to treatment, including, but not limited to, fracture, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its 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 condition(s), for any future condition(s) for which I seek treatment, and for maintenance/wellness care.

FINANCIAL AGREEMENT

The undersigned patient and/or responsible party hereby acknowledges responsibility for all chiropractic services and costs that are provided by Burgess Chiropractic, P.A.

This personal obligation is not affected by any obligation of insurance companies to pay your health care costs. If an insurance payment is not received, you are responsible for all chiropractic care costs.

In the event that chiropractic care plans are not completed, any advanced payments will be adjusted at the full rate of services and refunded accordingly.

Furthermore, I understand that no doctor, of any kind, can or should guarantee any "cure" for any course of treatment and that no spinal correction can therefore be guaranteed.

Patient Signature_____ **Date**_____

Doctor Signature_____ **Date**_____