SPORTS CHIROPRACTIC INSTITUTE

1290 W. Spring Street, Suite 130, Smyrna, GA 30080

Informed Consent

I (the patient/guardian) hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and massage or soft tissue therapy on myself (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future work at Sports Chiropractic Institute. On field care may consist of minor first aid, injury assessment, and/or emergency first responder care in conjunction with on field athletic trainers, emergency medical technicians, paramedics, and other health care staff. In the event of emergency, the parent/guardian will be notified as soon as possible.

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

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, 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 and for any future condition(s) for which I seek treatment.

Patient/Athlete Signature_____ Date _____

Parent/Guardian Signature _____ Date_____