Mason Chiropractic and Rehabilitation Center, LLC ~ 111 Reading Road ~ Mason, Ohio 45040 ~ (513) 398-2020

CONSENT TO TREAT

Patient Name: _____ Date: _____ Patient #: _____

I request and consent to the performance of chiropractic, examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State law, including medical records review, various modes of physiotherapy and any necessary diagnostic and interpretation of x-rays on myself by a radiologist and/or chiropractic radiologist (or on the patient named below, for whom I am legally responsible) by any of the treating doctors of chiropractic on staff and/or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening symptoms. 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 to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize Mason Chiropractic and Rehabilitation Center, LLC to treat me.

I have read and understand the foregoing.

Patient's Signature: _____ Date: _____

CONSENT TO TREAT A MINOR

Patient Name: _____

I hereby request and authorize Mason Chiropractic and Rehabilitation Center, LLC to perform diagnostic tests, render chiropractic adjustments and other treatment to _____.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature: _____ Date: _____

_____ _____

Printed Name Relationship to Patient

(Authorization expires three years from date above)