Informed Consent of Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me, (or the patient named below, for whom I am legally responsible), including diagnostic X-rays; and/or various healing therapies, by a licensed doctor who now or in the future will treat me while employed by, working or associated with or serving as back-up for doctor of chiropractic of named facility, including those working at the clinic or office listed. I also give my permission to receive treatment by any supervised chiropractic assistants who may provide support treatment on my behalf.

**I have had the opportunity to discuss with the doctor and/or with other office of clinic personnel the nature and purpose of the treatments.** I understand that the 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 factures, 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 on doctor to exercise judgment during the course of the procedure which they feel at the time, based upon the facts known then, will be 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 the chiropractic procedures** and by signing below, I agree to the named procedures. I intend this consent form to cover the entire course of treatment for my present condition. I may withdraw my consent at any time, as long as it is done in writing and submitted to the treating doctor. **I also give my permission for this consent to treat, to be valid for any other future conditions which I may discuss and receive treatment for at Integrative Medicine and Holistic Wellness Center.** If I am involved in an accident, or have significant new injuries, I may be asked to authorize a new consent to treat form.

PRINTED PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNED PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_

PRINTED PATIENT REPRESENTATIVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNED PATIENT REP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_

DOCTOR’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_

**Kyle Corbin, DC, PA**

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