Patient: _____ Date of Birth: _____

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or on the patient named below, for whom I am legally responsible) by Dr. Rachel Bailey DC. I understand that therapy and diagnosis may include X-rays, orthopedic examinations, muscle function evaluation, trigger therapy, chiropractic adjustments, diet or nutritional counseling, lifestyle and ergonomic recommendations, and more.

I have had an opportunity to discuss with Dr. Rachel Bailey DC the nature and purpose of chiropractic adjustments and other procedures, and ask questions regarding my exam and treatment plan. I have been informed and I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to fractures, strokes, or dislocations.

I have read the above consent, 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 at Austin Hills Chiropractic.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____