DILLON CHIROPRACTIC OFFICE
114 JOHN STREET
SALINAS, CA 93901-3321
PHONE: (831) 449-1594 FAX (831) 449-8157

CONSENT TO TREAT FORM

INFORMED CONSENT FOR CHIROPRACTIC CARE
By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures whether he/she is suffering from pathological conditions (latent or otherwise), illnesses, injuries, or deformities which would otherwise not come to the attention of the doctor.

To the patient

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.

I have read and understand the foregoing explanation of chiropractic care given to me. I hereby give my consent for the doctor to render chiropractic care to me.

Patient's Signature:_____ Date:_____