Lake Zurich Wellness Group

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WELCOME TO OUR OFFICE

I hereby request and consent to the performance (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic who now or in the future work at this office listed above. I will have opportunity to discuss with the doctors of chiropractic practicing in this clinic and/or with other office or clinic personnel the nature and purpose of the procedures indicated above. I understand that results are not guaranteed if I consent to treatment.

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 will have an opportunity to ask questions about its content, and by signing below I am agreeing to the treatment recommendations that the doctor will lay out for me with the exception of the procedures I decline to undergo. By declining any of the procedures, I understand that the doctor may be working from limited information and that I understand and take full responsibility for the fact that this may affect the overall outcome of my care and possibly not reveal any potential abnormal findings that would be viewed or exposed with the use of further diagnostic investigation.

I intend for this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment for at this office.

Patient Name (please print): _____ Account # _____

By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

Patient Signature: _____ Date: _____

Witness Name (please print): _____

Witness Signature: _____ Date: _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.