INFORMED CONSENT FOR CHIROPRACTIC CARE AND TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by Dr. Heather B. Faye or her appointed assistant or intern, affiliated with Faye and Faye Chiropractic, Inc.

I understand that as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, although very rare, 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. 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, is in my best interest.

I have read, or have had read to me, the above consent. By signing below, I agree to the above and allow the doctor, assistant or intern affiliated with Faye & Faye Chiropractic Inc., to perform such. I intend this consent form to cover the entire course of treatment for my or for whom I'm responsible for present condition and for any future conditions for which I or whom I am responsible for, seek a consultation and/or treatment.

_____
Patient Name

_____ _____
Patient Signature Date

If patient is a minor under the age of 18:

_____
Patient Name

_____ _____
Parent or Guardian's Signature Date

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