

Dr. Jon M. Postajian

Chiropractor

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapeutics and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Jon M. Postajian, DC.

I understand 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 of the risks and complications, and 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 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.

Dr. Postajian will discuss any further risks inherent for my particular condition during a report of findings procedure and document this discussion on the reverse side of this document. Any questions that I may have will also be addressed at this time.

Patient's Name (Please Print)

Date

Signature of Patient Or Guardian if Patient is a Minor