Informed Consent for Chiropractic Treatment and Care

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care of treatment.

I understand have the right to see and receive a copy of your health information.

I hereby request and consent to the performance of chiropractic adjustments, physical examination, soft tissue procedures, physiotherapy and diagnostic x-rays if warranted on me should I elect to seek care from Drs. Llantada and Mar on game day or in office. I consent to allow Dr. Mar evaluate and treat me on an emergency care basis on game day should I be in a condition where I am not able to authorize verbal consent.

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, sprains, disc injuries, dislocations, fractures and stroke in extremely rare cases. 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 judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, and are in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctors of Llantada & Mar Professional Chiropractic Corporation to perform such. 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.

________________________________________
PATIENTS NAME (PLEASE PRINT)

________________________________________
DATE

________________________________________
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE