Eastside Chiropractic, P.C.
1011 Woodridge Lane, Building 301
Watkinsville, Georgia 30677
Dr. Bryan Hooper

Informed Consent for Treatment

Chiropractic care can be associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. Some risks can include fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise professional medical judgement based upon the facts known to him to do what is in my best interest during the procedure. I have had the opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. The doctor will not be held responsible for any preexisting medically diagnosed conditions.

By signing this consent, I hereby authorize the physicians and staff at Eastside Chiropractic to treat my condition as deemed appropriate using chiropractic adjustments and procedures, including various modes of physical therapy. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment from the doctors at Eastside Chiropractic, PC.

I have read and understand this policy and all my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Patient's signature (or legal guardian) Patient's Printed Name

Date: _____