INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The undersigned requests and consents to the performance of chiropractic adjustments and/or other chiropractic procedures as deemed necessary by Ben M. Chozen, DC.

I further understand that Ben M. Chozen, DC may perform other chiropractic procedures on me in the future at this office. I've had an opportunity to discuss with Ben M. Chozen, DC the nature and purpose of the chiropractic adjustments and/or other procedures, and I understand that the results are not guaranteed.

I understand, and I am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment; including, but not limited to, fractures, disc injuries, strokes (CVA), dislocations and sprains. I do not expect Ben M. Chozen, DC to be able to anticipate and explain all risks and complications. Further, I wish to rely on Ben M. Chozen, DC judgement during the course of the procedure or procedures which Ben M. Chozen, DC feels are in my best interest at the time and based upon facts then known.

I have read or had read to me this content. I have had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by Ben M. Chozen, DC. I intend this consent form to cover the entire course of treatment for my present condition and for any conditions for which I may seek treatment in the future from Ben M. Chozen, DC.

_____
Print Patient's Name

_____
Patient's Signature

_____
Date

_____
Physician's Signature

_____
Date