Shari Ough, DC
Albany Hill Health Center
514 Kains Ave., Albany, CA 94706
510-527-7443

INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Shari Ough, D.C. or other licensed Doctor of Chiropractic who now or in the future treat me while working or associated with or serving as back-up for Dr. Ough, including those working at the office listed below or any other office or clinic.

I have an opportunity to discuss with Dr. Ough and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed 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 risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and 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.

______________________________ Print Patient's Name

______________________________ Signature of Patient or Representative

______________________________ Print Representatives Name

______________________________ Relationship to Patient

______________________________ Witness to Signature

___________ Date