UTC CHIROPRACTIC

Informed Consent

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible for: ___________________________) by Dr. Josh Caldwell, D.C. and/or anyone working in this office authorized by above referenced Doctor of Chiropractic.

I further understand that such chiropractic services may be performed by the UTC Chiropractic Clinic and/or other licensed Doctors of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Josh Caldwell, D.C. and/or his other staff or clinical personnel the nature and purpose of Chiropractic Adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of Chiropractic carries some risks to treatments, including but not limited to: sprains, fractures, disc injury, burns, dislocations and strokes. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Further, I wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels are in the best interest at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) for which I seek treatment at this facility. If in the rare case I am injured, I release any and all liability from UTC Chiropractic, Dr. Josh Caldwell and anyone under his employ at the time of the incident.

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Printed Name of Patient

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Signature of Patient

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Signature of Patient's Representative (if patient is a minor)

Date: _______________