



# WINTERS CHIROPRACTIC & ACUPUNCTURE

## Consent to Treat

Please read the following statements, INITIAL all that you agree to, and sign below:

- \_\_\_\_\_ I have received Chiropractic care in the past.
- \_\_\_\_\_ I understand that Chiropractic care does not involve the use of drugs or surgery.
- \_\_\_\_\_ I am aware that as with all medical procedures and services, there are certain risks involved.
- \_\_\_\_\_ I will discuss all information regarding my past medical history with the doctor.
- \_\_\_\_\_ I give permission to Winters Chiropractic & Acupuncture to treat me as medically necessary.
- \_\_\_\_\_ To the best of my knowledge, all information provided to Winters Chiropractic & Acupuncture is accurate and true.
- \_\_\_\_\_ I have received the notice of privacy practices and I have been given the opportunity to review it.

Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

## Consent to Treat a Minor

Name of Minor \_\_\_\_\_

As legal guardian/parent, I give Winters Chiropractic & Acupuncture permission to provide treatment for \_\_\_\_\_ as deemed medically necessary.

Legal Guardian / Parent Signature \_\_\_\_\_ Date \_\_\_\_\_