

INFORMED CONSENT TO CHIROPRACTIC CARE

RIVANO CHIROPRACTIC HEALTH CENTER, L.L.C.
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135 Columbia Turnpike, Suite 301
Florham Park, N.J. 07932
Telephone (973) 845-6282
Fax (973) 845-6283

Patient Name _____ Birthdate _____

Please discuss any questions or concerns with Dr. Rivano before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy by Dr. Rivano.

I have had the opportunity to discuss with Dr. Rivano and/or other office personnel the purpose and benefits of the chiropractic adjustments and other treatments. Alternatives to chiropractic treatments will be reviewed following the initial consultation.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Doctor's Signature _____
Date _____