In Motion Chiropractic, P.C.
1786 Flatbush Ave- Brooklyn, NY 11210
Phone: 929-333-9955

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and benefits and risk of treatment. This information will assist you in making an informed decision. As with all forms of treatment from taking an over the counter medication, receiving massage therapy or exercise therapy, to medical treatment and invasive procedures and even doing nothing at all, your choice carries benefits and risks.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of rehabilitative therapy. The chiropractic treatment may be performed by In Motion Chiropractic, P.C. and the Doctor of Chiropractic, Dr. Darren T. Mollo, and/or licensed Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic.

I understand that, there are some risks to chiropractic treatment including, but not limited to, sprains, strains, dislocations, fractures, aggravation of condition, no improvement, and burns or frost bite from rehabilitative therapy. In extremely remote cases there have been reported complications of vertebra-vascular injury (stroke) when a patient receives a cervical adjustment.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
(Print Name)

_____
(Signature of Patient)

_____
(Date Signed)

To be completed by the Patient's Representative:

_____
(Print Name of Patient)

_____
(Print Name of Patient's Representative)

_____
(Signature of Patient's Representative)

As:_____
Relationship/Authority of Patient's Representative

_____
(Date Signed)

To be completed by Doctor or Staff:

_____
Witness to Patient's Signature

_____
Date

_____
Translated by

_____
Date