

Fefles Family Chiropractic

11555 South Harlem Ave., Suite C

Worth, IL 60482

INFORMED CONSENT

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, and intervertebral disc injury, and cardiovascular accident. I understand that Fefles Family Chiropractic will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interest considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and hereby consent to voluntary participate in orthopedic, neurological, and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate by Fefles Family Chiropractic. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my doctor.

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|--------------------|-----------|-------|
| _____ | _____ | _____ |
| Print Patient Name | Signature | Date |

If patient is a minor:

| | | |
|----------------------------|-----------|-------|
| _____ | _____ | _____ |
| Print Parent/Guardian Name | Signature | Date |

| | |
|------------------------|-------|
| _____ | _____ |
| Chiropractor Signature | Date |