BOARDMAN FAMILY CHIROPRACTIC, P.C. &
SPINAL AID CENTER
JOHN E. BOARDMAN, D.C.
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INFORMED CONSENT

My signature below, certifies that I _____ have read (or have had read to me) this informed consent. I've had an opportunity to personally discuss it with a doctor or staff member, and understand the following:

- In this office, the Chiropractic practice is augmented with the use of physio-therapy, and/or rehabilitative exercise therapy. Although they might not be specifically licensed or degreed, the staff is skilled in the use of these adjunctive therapies. I personally request and consent to examination, the diagnostic x-rays that may be necessary, and Chiropractic treatment by the clinic's doctor(s) of Chiropractic. Further, I agree to any modality, therapy, manipulation, or rehabilitation exercise that in the doctor's opinion is necessary in my case. I hereby give permission for clerical as well as health care staff to have access to my personal health records both during the time of treatment and afterwards.

- When necessary, and with this document acting as proper release thereof, I hereby authorize Boardman Family Chiropractic, P.C. to release and/or obtain any information required in the course of my examination or treatment (i.e. records, x-rays, reports, etc.).

- I knowingly and willingly accept treatment, understanding that although rare, there maybe certain risks inherent with physical medicine, Chiropractic, physio-therapy techniques, and/or rehabilitation exercises and other clinical procedures. these risks rarely involve, but are not limited to: sprains and strains, spinal disc irritation, or in very rare incidents (with certain high risk patients) stroke. I do not expect the doctor(s) to anticipate, nor explain all of the risks, and/or complications that are possible, but I will rely on the Doctor(s) training and education to exercise professional judgment during the course of any procedure or protocol which he/she feels necessary, based on the facts and diagnosis in my case, knowing that he/she will act in my best interests.

- This consent noted herein will remain in effect throughout my active treatment program, for maintenance care, for future care, and until personally revoked by me.

Patient's Signature:_____ Date_____

Witness Signature:_____ Date_____

Signature of (Minor's) or Patient's Authorized Representative:

_____Date_____