

## **INFORMED CONSENT FOR CHIROPRACTIC CARE**

As a patient coming to The Pain Relief Center I give Doctor Stephen Dohoney, and his staff authority to treat me in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustments and other clinical procedures are, in most cases beneficial and rarely cause problems or injury. In these rare cases problem or injury is due to underlying physical defects, deformities, illnesses and/or pathologies. As a patient I understand it is my responsibility to make such conditions, which would not otherwise be discovered or obvious, known to Dr. Dohoney before treatment. I am aware that Dr. Dohoney is a licensed chiropractor and any risk involved, regarding treatment will be explained to me upon my request. I understand that by being accepted as a patient I am authorizing The Pain Relief Center to proceed with any treatment that may be necessary.

***I have read and understood the Informed Consent for Chiropractic Care.***

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

## **CONSENT TO TREAT A MINOR**

As a parent/guardian of \_\_\_\_\_ (name of patient) I have read and understood the above consent form and authorize Dr. Stephen Dohoney and his staff to examine and treat the minor in my care as they see necessary.

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Parent/guardian name

\_\_\_\_\_  
Parent/ guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff witness signature