

INFORMED CONSENT TO PARTICIPATE IN CHIROPRACTIC CARE
GET IN-LINE CHIROPRACTIC AND KENDRA COHN, DC

I, the undersigned, have voluntarily requested that Dr. Kendra Cohn assist me in the management of my health concerns. I understand that Dr. Cohn is a Doctor of Chiropractic and that her services are not to be construed or serve as a substitute for standard medical care. Dr. Cohn recommends that I undergo regular routine medical check-up by my medical doctor.

I hereby request and give consent to the performance of chiropractic adjustments and other chiropractic procedures, including conservative noninvasive treatment to the joints and soft tissues, various modes of physical therapy and diagnostic x-rays. Physical therapy, home exercises, and nutritional supplements/dietary recommendations may also be used. This consent is for myself, (or on the patient named below, for whom I am legally responsible) to be treated by Dr. Cohn and/or other licensed Doctors of Chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic under Get In-Line Chiropractic.

I have had an opportunity to discuss with Dr. Cohn and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. This includes but is not limited to: soreness, dizziness, fractures, disc injuries, strokes, dislocations and sprains. Should I experience any of these symptoms during or after the time of treatment I will consult Dr. Cohn. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name _____ ;

Patient Signature _____ Date _____

I, being the parent or legal guardian, hereby authorize Dr. Kendra Cohn, and whomever she may designate as assistants to administer treatment as deemed necessary to my minor child.

Print Name _____ Relationship to child _____

Patient Signature _____ Date _____