ALLEGHENY CHIROPRACTIC AND REHAB

CONSENT TO CARE

I hereby authorize the Doctor's to treat me care as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injection and diagnostic testing. I realize the goal of holistic healthcare of to strengthen the patient's body in order to heal themselves.

A patient coming to the doctor provides him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare services, if known or to learn through health care procedures or diagnosis, that the symptoms from whatever he/she is suffering from are related to latent pathological defects, illness, or deformities, which would otherwise not come to the attention of the physician.

It is understood and agreed that amount paid the clinic for x-rays for interpretation and only the x-rays negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

I have read and understand the foregoing.

Patient's Signature: _____ Date: _____

X-RAY QUESTIONNAIRE FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- There is a possibility that I may be pregnant at this time
- Yes, I am definitely pregnant
- No, I am definitely not pregnant at this time
- I request that x-ray films not be taken because:

_____

_____

Date of last menstrual period: _____

Patient Signature: _____ Date: _____