

east west wellness of marin

209 san anselmo ave. san anselmo ca. 94960

INFORMED CONSENT TO CHIROPRACTIC TREATMENT:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, other forms of testing (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the chiropractic physicians at **east west wellness** and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I understand that I will be given the opportunity to discuss with dr eve bernstein and any practitioner at east west wellness of marin, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I also understand that during my appointment at **east west wellness** I will be given the opportunity to ask questions to my treating Chiropractor about its contents and by signing below, I agree to the treatment recommended by my Physician of Chiropractic. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

Print Patient's Name

Print Name of Representative

Signature of Patient

Signature of Representative

_____/_____/_____

_____/_____/_____

Date

Date