DR. GLORIA PHILLIPS
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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures, including examination, diagnostic testing, massage therapy, physical therapy techniques and modalities, on me (or on the patient named below for whom I am legally responsible), which are recommended by Dr. Gloria Phillips or other licensed doctors of chiropractic or massage therapist who now or in the future render treatment to me while employed by, working for, or serving as a back-up for, or associated with Dr. Phillips.

Chiropractic manipulation and care, as well as massage care considered to be some of the safest, most effective methods of treatment. However, I understand that, as with any health care procedure, there are certain complications that may arise during a chiropractic manipulation. Those complications include, but are not limited to: soreness, dizziness, muscle strain, fractures, disc injuries, dislocation, neurological complications, and I do not expect Dr. Phillips to be able to anticipate and explain all the risks and complications possible. I wish to rely upon Dr. Phillips to exercise her judgment during the course of the procedure that she feels at the time, based upon the facts then known to her, and is in my best interest.

I understand that I am responsible for monitoring my own condition throughout the treatments and will inform Dr. Phillips of any unusual symptoms that might occur. I also understand that results are not guaranteed and that healing is a process.

I have had the opportunity to discuss with Dr. Phillips the nature and purpose of my care that may include, but is not limited to, chiropractic manipulation, massage therapy, physical therapy modalities, and therapeutic exercise, and nutrition and lifestyle recommendations.

I have read or have had it read to me the above explanation of possible treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided it is in my best interest to undergo the recommended treatment. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

PATIENT NAME:_____

PATIENT SIGNATURE _____

DATE:_____