MOUNTAIN COMMUNITY CHIROPRACTIC WELLNESS CENTER

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future will treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below 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.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, 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 q2uestions 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.

To be completed by patient:

_____
Print name of Patient

_____
Signature of Patient

_____
Date signed

Dr. Tirrell S. Magnuson
33 Valley View Terrace
Waynesville NC 28786
828-452-9060

70 Woodfin Place
Asheville NC 28801
828-226-6089

To be completed by patient's representative (minor child or physically/legally incapacitated):

_____
Print name of Patient

_____
Print name of Patient's Representative

_____
Signature of Patient's Representative

As:_____
Relationship of Representative

_____
Date Signed