**Informed Consent**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, (Cold Laser) including various modes of manual therapy and diagnostic X-rays, on me (or on 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 work at Goodland Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office staff of the nature and purpose of chiropractic adjustments. I understand that everyone responds differently to chiropractic care.

I understand and am informed that, as in any healthcare procedure, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and muscle sprains, costo-vertebral strains and separations. Sometimes patients will feel stiffness or soreness following the first few days of treatments. Dr. Bellefeuille will do a complete and thorough examination to screen for any contradictions to care; however, if you have a condition that would otherwise not come to their attention, it is your responsibility to inform the doctor. In signing this form, 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 at Goodland Chiropractic. I intend this form to cover the above and accept the risks and consequences of their application.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of manual therapy and diagnostic x-rays on me (or on the patient named below for whom I am legally responsible for) by the Doctor of Chiropractic at Goodland Chiropractic.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR MINOR USE ONLY:**

I hereby authorize Dr. Justine Bellefeuille D.C. and whomever she may designate as assistants to perform diagnostic test and render chiropractic adjustments and other treatment to MY MINOR CHILD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I give Goodland Chiropractic the right to (adjust/examine/x-ray/massage/preform physical modalities on) my child.

Parent or legal guardians signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial if your child may be treated **without** a parent or legal guardian being present. \_\_\_\_\_\_\_\_\_\_