



Budincich Chiropractic Clinic, Inc.
Michael N. Budincich, D.C. & Associates

**INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND
CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Budincich Chiropractic Clinic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some extremely rare risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. For instance, recent 2007 research showed that the risk of getting a stroke from chiropractic treatment is the probability of 1 chance in 3.5-4.5 million treatments. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Budincich Chiropractic Clinic, Inc to perform such. 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 from any doctor at Budincich Chiropractic Clinics, Inc.

Patient's Name (Please Print)

Date

Patient or Guardian's Signature