INFORMED CONSENT
P3 Sports Care and Patient Agreement

We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between the provider and patient.

PATIENT INITIAL_____

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager. If the account in not paid within 90 days of the date if service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

PATIENT INITIAL_____

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 P3 Sports Care.

PATIENT INITIAL_____

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations, muscle soreness, bruising and sprains.

PATIENT INITIAL_____

I do not expect the doctor to be able to anticipate and explain all risks and complications.

PATIENT INITIAL_____

I wish to rely on the doctor or intern to exercise judgment during the course of the procedure, which the doctor feels at the time, based on the facts then known, is in my best interest. I also authorize the provider to release any information required to process insurance claims

PATIENT INITIAL_____

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 P3 Sports Care 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.

PATIENT INITIAL_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understanding it is my responsibility to inform this office of any changes to the information I have provided.

___________________________ ___________________

Patient's Name (Please Print) Date

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Patient or Guardian's Signature

THIS DOCUMENT HAS BEEN REVIEW BY ME WITH MY TREATING DOCTOR OR INTERN

- Patient Initial_______ Doctor Initial______ Date:_________