



**CONSENT TO PHYSICAL THERAPY AND /OR CHIROPRACTIC SERVICES**

I, \_\_\_\_\_, authorize the performance upon myself of  
(Patient Name)  
the following procedure(s):

**EXAMINATION AND/OR TREATMENT**

I realize that these procedures are to be performed by or under the direction of doctors, associates, or assistants employed by Advanced Injury Treatment Center.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above named doctor, associates or assistants, may consider necessary or advisable in the course of my health care.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above named doctor and/or associates and assistants.

I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by the above named doctor, associates or assistants.



\_\_\_\_\_

Signature of Patient

\_\_\_\_\_

Date