**Matthew J. McIlrath, D.C., C.M.U.A.**

**DrMattMcIlrath@Yahoo.com**

 **1201 Philadelphia Pike 526 Kennett Pike**

 **Wilmington, DE 19809 Chadds Ford, PA 19317 Phone: 302-798-7033 Fax: 302-798-7216 Phone: 610-388-0388 Fax: 610-388-0188**

**Informed Consent of Chiropractic Treatment**

I hereby request and consent to the performance of chiropractic treatment including manipulation and other chiropractic procedures including various modes of physiotherapy, massage therapy, and diagnostic x-rays, if necessary, on me / or on the patient named below, for whom I am legally responsible by the chiropractic physician at Health One Chiropractic and/ or anyone working in this office authorized by the chiropractic physician Dr. Matthew J. McIlrath.

I further understand that such chiropractic services may be performed by the physician at Health One Chiropractic and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Matthew J. McIlrath and/or with other office or clinic personnel the nature and purpose of chiropractic treatment and other procedures. I understand that results are not guaranteed.

I understand and am informed that the practice of Chiropractic Medicine, an in all healthcare, carries some risks of treatment which are minimal; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intent this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility in the future.

To be completed by the patient’s

Representative, if necessary, (e.g.

If the patient is a minor or is

Physically or mentally incapacitated)

To be completed by the patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name Print Name of Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Signature of Representative

\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date Date

Physician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_