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QUINTESSENTIAL CHIROPRACTIC PLLC

DR. NICK QUINN, D.C.
DR. TANYA QUINN, D.C.
FAX. 603.319.4217

A FAMILY HEALTH OASIS

INFORMED CONSENT

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, on myself, (or on the patient named below, for whom I am legally responsible) by **Quintessential Chiropractic PLLC (Dr. Tanya Quinn, D.C.)**, and/or other licensed doctors of chiropractic who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for **Dr. Tanya Quinn, D.C. ,** whether or not their names are listed on this form.

I understand and consent to the following procedures: examination, x-rays (if needed), neck and spine/extremity adjustments, joint mobilization, electrical therapies, traction, and/or other procedures recommended for my condition(s).

I have had an opportunity to discuss with the doctor named above, the various types of treatment, including spinal adjustments, that have been proposed to me for my condition, and the purpose and objectives of these chiropractic procedures. I understand that the results from the chiropractic treatment are not guaranteed for my condition.

I have been informed about the risks and benefits of chiropractic adjustments and other chiropractic procedures, and understand that, there are some uncommon potential serious risks to chiropractic adjustments and procedures, including, but not limited to, sprains, fractures, disc injuries, dislocations, and nerve injuries. I understand and have had the opportunity to ask about risks and benefits the proposed treatment and of other alternative types of treatment for my condition.

I have had the opportunity to read this form understand the above statements, accept the risks mentioned, and hereby consent and agree to chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

PATIENT NAME (PRINT): _____DATE: _____

X_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

NAME: _____ RELATIONSHIP: _____
Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor):