**DR. JAMES B. YOUNG**

## Disclosure & Consent
## Chiropractic Adjustments and Care

**To the patient:** You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you. It is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedure. Including various modes of physical therapy and diagnostic X-ray, on me (or the patient named below for whom I am legally responsible) by James B. Young DC. I have had the opportunity to discuss with Dr. Young my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. *I understand and I am informed that in the practice of chiropractic there are some risks to exam and treatment including, but not limited to fractures, disc injuries, strokes, dislocations, sprains, increased symptoms and pain or no improvement of symptoms or pain*. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise good judgment during the course or the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and acceptably. By signing below, I consent to the treatment plan. 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.

I consent to receive care and authorize Dr. James B. Young to perform the necessary tests and take any necessary X-rays required to treat me safely and effectively. (Female Patients) To the best of my knowledge I am NOT pregnant.

***To be completed by patient:***

_____
Print name

_____
Signature of patient

_____
Date signed

_____
Staff signature

***To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:***

_____
Print name of patient

_____
Print name of patient's representative

_____
Signature of patient's representative

As:_____
Relationship or authority of patient's representative

_____
Date signed

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