INFORMED CONSENT TO
CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to : fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

Name(s) and Address(s) of Office or Clinic

San Antonio Spine & Rehab
1313 SE Military Dr. Ste. 107
San Antonio Tx 78214

San Antonio Spine
4242 Woodcock Dr. Ste 100
San Antonio, TX. 78228

Print Name(s) of Doctor(s) Treating
This Patient

Dr. Valerie A. Lopez, DC
Dr. John Raimondo, DC
Dr. Richard Alexander, DC
Dr. Sidnie Morris, DC
Mr. Eugene Benedict LPC

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

____________________________ ____________________
Printed Name of Patient Date

____________________________ ____________________
Signature of Patient Date

____________________________ ____________________
Signature of Patient's Representative Date
(if minor or physically incapacitated)
Witness to Patient's Signature