Rock River Chiropractic & Acupuncture
Treatment of Minor Patient Informed Consent Form

I hereby authorize Dr. Lori Nelson, D.C., and assistants acting under their responsibility and supervision, to perform diagnostic tests and render chiropractic treatment and/or acupuncture to my minor child_____, date of birth_____.

I hereby affirm that I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my dissolution of marriage or separation, I have the legal right to select and authorize this care for my minor child without consent of my spouse/former spouse. If my authority to authorize such care is revoked or modified, I will immediately notify this office.

I have had the opportunity to discuss with Lori Nelson, D.C., or other clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of chiropractic medicine is not an exact science and that my child's care may involve the making of judgments based on the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment or treatment; that no guarantee as to results has been made to or relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my child's best interests.

I have also been advised that, although the incidence of complications associated with chiropractic services in very low, anyone undergoing adjustment or manipulative procedures should know of possible complications which have been alleged. These include, but are not limited to, factures, disk injuries, strokes, dislocations, sprains and those which related to physical aberrations unknown or reasonably undetectable by the doctor.

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 on behalf of my minor child, acknowledge my understanding of its contents.

Date: Patient/Minor Child's Name:

Authorized Parent/Guardian Signature:

Authorized Parent/Guardian Printed Name:

Relationship or Authority to Minor Patient: