INFORMED CONSENT

I hereby request and consent to the performance of joint mobilization, osteopathic or chiropractic manipulation, physiotherapy or other medical procedures including diagnostic x-rays (if necessary) on me or, the patient named below, for whom I am legally responsible, by the doctors and staff at **HEALTHWORKS!**

I have had, or will be responsible for having, such discussions with the doctors and staff at **HEALTHWORKS!** that will provide, or has provided me with the opportunity to become fully apprised of the nature and purpose of joint mobilization, osteopathic or chiropractic manipulation, as well as the various physiotherapeutic and medical procedures performed by the doctors and licensed or otherwise qualified staff at **HEALTHWORKS!**

I understand and am fully informed that, in the practice of physical medicine, there are risks, including but not limited to, dislocation, fracture, disk injury, stroke, sprains and strains. I do not expect the doctors or staff at **HEALTHWORKS!** to be able to anticipate and explain all the risks and complications potentially inherent in physical medicine, but instead, I wish to rely upon those employed by, or those who work at **HEALTHWORKS!** to exercise good judgment in the prudent application of a course of treatment, prescribed in my best interest and based upon the known facts regarding my condition.

I have read, or have had read to me, the above informed consent and have had the opportunity to ask questions regarding its contents. By signing below I acknowledge all that is memorialized above and intend that this informed consent cover the entire course of treatment for my current condition and any future conditions for which I may seek care.

TO BE COMPLETED BY PATIENT or LEGAL REPRESENTATIVE

Patients Name (Print Please)_____

Signature of Patient _____

Signature of Legal Representative _____

Relationship or Authority of Patient's Legal Representative _____

Witness _____Date Signed_____