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 **Amber D. Mason Riggs, DC** and/or **Jillian Maconachie, DC** 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 and licensed contractors that are employed by, associated with, or serve as back-up for **Amber D. Mason Riggs, DC** and/or **Jillian Maconachie, DC**, whether or not their names are listed on this form.

I understand and consent to the following procedures: examination, neck and spine/extremity adjustments, joint mobilization, electrical therapies, traction, class IV laser therapy, therapeutic massage, neuromuscular reeducation and or other procedures recommended for my condition(s).

I have had an opportunity to discuss with **Amber D. Mason Riggs, DC** and/or **Jillian Maconachie, DC** 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 adjustment s 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, nerve injuries and strokes, specifically from neck adjustments. I understand and have had the opportunity to ask about risks and benefits of the proposed treatment and 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 – PLEASE PRINT DATE

____ _______________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

____ _______________________

SIGNATURE IF **OTHER** THAN PATIENT DATE

RELATIONSHIP TO PATIENT: ☐ Mother ☐ Father ☐ Stepmother/father ☐ Legal guardian ☐ _____________

OFFICE/ WITNESS SIGNATURE:___________________________________DATE:____________________

Back In Motion Chiropractic, LLC
4341 B Street Ste 100
Anchorage, AK 99503
Phone: (907) 562-CARE[2273] Fax: (907) 562-2263

2012