**DR. MICHAEL BANK, D.C.**
**8011 S. COOPER ST STE. 101**
**ARLINGTON, TX 76001**
**PHONE: 817-453-9339**
**FAX: 817-453-9380**

## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

i hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-rays. The particular diagnosis and treatment plan for my file have been explained to me.

I understand that the practice of chiropractic is not an exact science, that individuals respond differently to treatment, and that there are no guarantees of the result of any treatment. I understand that the examination and treatment involves certain risks and those risks have been explained or provided to me. I do not expect the doctor to be able to anticipate and explain all imaginable risks and/or contraindications, and I wish to rely on the doctor to exercise his judgment based on the facts known to be in my best interest during the course of my treatment. I understand that the doctor is a licensed chiropractor in the state of Texas and by such is licensed to employ objective or subjective means without the use of drugs, surgery, x-ray therapy or radium therapy for the purpose of ascertaining the alignment of the vertebrae and/or injured extremity to correct any subluxation or misalignment. Accordingly, I understand the practice of chiropractic is limited to diagnosing and re-adjusting the spinal vertebrae and/or extremity when they are misaligned, in order to help cure or resolve musculoskeletal symptoms that result from such a misalignment.

I understand any and all doctors employed by this office disclaim being able to treat me for any maladies or symptoms that I may be experiencing that may not be related to the injuries reported to the doctor. It is not expressed or implied in this office that the treatments offered by the doctor will specifically cure any symptoms I may be experiencing in any other part of my body.

I have read and understood the above consent for chiropractic treatments and care. I have also had the opportunity to ask questions regarding this consent and my treatment plan. Further, I understand all charges incurred at **DR. MICHAEL BANK, D.C.** are ultimately my responsibility regardless of payment availability from another source. I therefore authorize examination and treatment to be performed by **DR. MICHAEL BANK, D.C.**

**PATIENT'S NAME: (PLEASE PRINT)**_____

**PATIENT'S SIGNATURE:**_____**DATE:**___/___/___

**NAME OF CUSTODIAL PARENT OR LEGAL GUARDIAN, ON BEHALF OF THE PATIENT:**

**(PLEASE PRINT)** _____

**PARENT/GUARDIAN SIGNATURE:**_____**DATE:**___/___/___