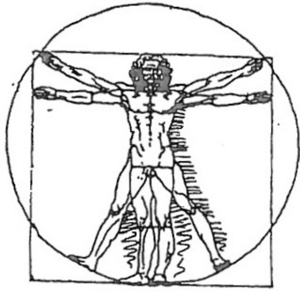

Dr. Giuseppe Corinella
Dr. Michael E. Davis

CONSENT TO CHIROPRACTIC TREATMENT

1. I, ____________________________, authorize the performance upon myself of the following procedure(s): Ultrasound, Sinusoidal Current, Traction and Chiropractic Manipulative Technique to be performed by or under the direction of Dr. Corinella and/or Dr. Davis.

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above-named doctor, associates or assistants, may consider necessary or advisable in the course of my health care.

3. The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above-named doctors and/or their associates and assistants.

4. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by the above-named doctors, their associates or assistants.

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Witness Date