

Permission to Test and Treat

I hereby request and consent to the administration of diagnostic procedures, chiropractic adjustments and other chiropractic procedures including, but not limited to, various modes of physical therapy and diagnostic x-rays administered by the staff at Chiropractic & Nutrition Wellness Center. I have been informed of the benefits and risks of chiropractic care and understand it is my responsibility to ask questions. I attest that the information completed by me on this form is correct and true to the best of my knowledge and agree to notify this office in the event of any change. Payment is expected for all office visits, services, treatments, procedures, and products purchased at the time of each visit unless other arrangements have been made with the business office personnel.

Signature of Patient or Guardian

Printed Name of Patient or Guardian

Date

Thank you for completing our health care questionnaire