INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the treatment of chiropractic adjustments. This includes various modes of physical therapy, chiropractic, and diagnostic x-rays performed for me (or the patient named below, for whom I am legally responsible). I request to be treated by the doctor named below and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor named below, including those working at South GA Spine and Joint Center.

I have had an opportunity to discuss this with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctors to be able to anticipate and explain all risks and complications, and I wish to rely on the doctors to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known is in my best interests.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient Name_____ Signature of Patient_____
Please Print
Date Signed_____ Witness of Patient's Signature_____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient Name_____ Signature of Patient_____
Please Print
Date Signed_____ Witness of Patient's Signature_____

Relationship or Authority of Patient's Representative_____

Translated by_____ Date_____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office: **South Georgia Spine and Joint Center**
Address: **202 S. Madison Street, Thomasville GA 31792 (229) 226-1035**
Address: **26 3rd Avenue NW, Cairo GA 39828 (229) 377-1392**

Name of Doctor(s) Treating this Patient:

Michael R. Waldrop, D.C.	PIN # 007773	Tony L. Rowe, M.D.	PIN # 58636
Heather H. Waldrop, D.C.	PIN # 007678	Gary Pratt, P.T.	PIN # 010234