Suwanee Family Chiropractic

Dr. Laura Russo, DC.
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Informed Consent to Treatment & Financial Care

I hereby request and consent to the performance of chiropractic adjustments, massage therapy and other procedures, including various modes of physical therapy, modalities and diagnostic testing on me (or on the person named below, for whom I am legally responsible) by **SUWANEE FAMILY CHIROPRACTIC and STAFF.**

I have had an opportunity to discuss with the doctor/facility named below and/or with other office or clinical personnel the nature and purpose of the treatment, modalities, and chiropractic adjustments.

I understand and am informed that as in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctors' judgment during the course of these procedures which at this time, based upon the current facts known, is in my best interest.

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

Print Patient Name

Print Name of Patient Guardian or Parent

Patient Signature

Guardian or Parent Signature

Today's Date (xx/xx/xxxx)