INFORMED CONSENT TO CHIROPRACTIC CARE

Lyresa Pleskovitch, D.C.
Nasim Gorgani, D.C.
The Spine and Therapy Center
2504 Ash Street
Palo Alto, CA 94306
(650) 327-0703

Patient: Please discuss any questions or concerns with Dr. Pleskovitch and/or Dr. Gorgani before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Lyresa Pleskovitch and/or Dr. Nasim Gorgani.

I have had the opportunity to discuss with the doctor(s) and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

I understand that I will be receiving the following treatment:

- **Chiropractic adjustments**
- **Physical therapy modalities (ultrasound, electric stimulation, heat, ice), if not contraindicated.**

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient: Date:

Print Patient Name:

Signature of Parent/Guardian: Date:
(if patient is a minor)

Witness Signature: Date:

Doctor's Signature: Date