OWATONNA NATURAL HEALTH CLINIC

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and nutritional recommendations, on me (or the patient named below for whom I am legally responsible) by Dr. Jodi Sampson and/or other licensed doctors of the chiropractic who now or in the future work at this clinic.

I have had an opportunity to discuss with the doctor of chiropractic the nature and purpose of the chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, the practice of chiropractic has some risks to treatment, including but not limited to fractures, disc injury, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known to him or her in my best interest.

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

Patient Signature:_____Date:_____

Witness Signature:_____Date:_____

Dr. Jodi Sampson, D.C.

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