MARCELLA BOX, D.C.
CHIROPRACTIC PHYSICIAN

ANDY CRUZ, D.C.
CHIROPRACTIC PHYSICIAN

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

_____ _____

Signature **Date**

PRIVACY POLICY: Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

_____ Do **not** want a copy _____ Received a copy

Signature _____ Date _____

CANCELLATION POLICY

To avoid being charged a $30 cancellation fee, I agree to give 24 hours notice.

Signature: _____ Date: _____