ATLAS MEDICAL CENTER
CONSENT TO TREAT

I hereby consent to a physical examination by an Atlas Medical Center physician and any diagnostic X-rays or laboratory tests associated with the medical examination, and where warranted on me (or on the patient named below, for whom I am legally responsible).

I understand that I will have an opportunity to discuss with the physician, the nature and purpose of the exam and other procedures.

I understand and am informed that in the practice of medicine and in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

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 exam/procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above. 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.

Patient Name (please print):_____

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____

Atlas Medical Center

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