FAMILY CHIROPRACTIC CARE
DR. JANE M. FITZGERALD
3170 East Tremont Avenue
Bronx, New York 10461
(718) 824-2002
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CONSENT FORM

I have received information about my condition and proposed chiropractic treatment program, as well as alternative courses of care, the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all healthcare, in the practice of chiropractic there are some rare risks to treatment, including but not limited to muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I do not expect Family Chiropractic Care to be able to anticipate or explained all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatments, which they feel at the time based upon the facts then known, is in my best interests.

Family Chiropractic Care had responded to all of my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content.

By signing below, I consent to chiropractic treatment.

Patient Name	Signature of Patient	Date
Parent/Guardian	Signature of Parent/Guardian	Date
Witness Name	Signature of Witness	Date
Doctor's Initials	Date	