

DAPHNE CHIROPRACTIC CENTER, L.L.C.

CONSENT TO CHIROPRACTIC MANIPULATION AND TREATMENT

I (we) hereby request and consent to the performance of chiropractic manipulation and other chiropractic or ancillary procedures, as deemed necessary on me or on _____, by Melvin A. Mashner, D.C., and/or other licensed doctors of chiropractic, designated staff, or professionals who may be employed by or engaged in practice in the Daphne Chiropractic Center, L.L.C. or Genesis Recovery Network. I hereby give authority for these procedures to be performed.

I have had an opportunity to discuss with Melvin A. Mashner, D.C., or other clinic personnel the nature and purpose of chiropractic manipulation and other therapy procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing manipulative procedures, physical therapy or rehabilitation should know the possible hazards and complications which may be encountered or result. These include but are not limited to, fractures, disc injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

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, agree to the named procedures.

Patient's Name (Please Print)

Patient's Signature

Relationship or authority if not signed by patient

Witness

Date

DOCTOR'S NOTES

Patient counseled by the use of the following:

_____ Discussion

_____ Other (please specify) _____