Informed Consent

Minicucci Chiropractic, PC (dba Total Health Concepts)

Kelly Minicucci, DC, FIAMA, Dipl.Ac

I hereby request and consent to the performance of chiropractic adjustments and other therapeutic procedures, including various modes of acupuncture, electrotherapy, gua sha, deep tissue massage and neuromuscular re-education, on me (or the patient named below, for whom I am legally responsible), by Dr. Kelly Minicucci.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, about the nature and purpose of chiropractic procedures and other procedures. I understand that results are not guaranteed.

I understand and I am informed that, as in the practice of medicine, there are some risks to chiropractic treatment. These include disc injuries, fractures, strokes and sprains. The gentle nature of our procedures will most likely not incur these injuries, and the doctor will exercise judgement as to what procedures to use in treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask about the consent, and by signing below I agree to the above-named procedures. This consent form will cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient
Signature_____Date_____

Witness
Signature_____Date_____