



## Trump Chiropractic & Acupuncture | trumpchiro.c

6871 West 91<sup>st</sup> Street; Overland Park, Kansas

### INFORMED CONSENT FORM

I (We) hereby request and consent to the performance of chiropractic and/or other Chiropractic procedures and/or Acupuncture Therapies on me or my child on \_\_\_\_\_, by Melinda Trump, D.C. and/or other licensed Doctors of Chiropractic who may be employed in practice in this clinic.

I have had an opportunity to discuss with the Doctor or other Clinic Personnel the nature and purpose of Chiropractic Adjustments and/or Acupuncture Therapies and procedures. I understand that the practice of neither Chiropractic, Acupuncture, or Medicine is an exact science, and that my care may involve the making of judgments based upon the facts known to the Doctor to be able to anticipate or prevent complications, that an undesirable result does not necessarily indicate negligence or judgment, that no guarantee as to results has been made to nor relied upon, and I wish to rely on the Doctor to exercise judgment during the course of treatment. The Doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that there are certain degrees of risk associated with Chiropractic Health Care including, but not limited to, fractures, disc injuries, stroke, and strains/sprains and am therefore willing to accept and consent to the risks associated with the care that I am about to receive.

I have read or have had explained to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below a consent form to cover the procedures prescribed for my condition and conditions for which I seek treatment.

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Patient's Signature

Patient's Name (Print)

