CONSENT TO EXAMINATION

I consent to an appropriate examination by the chiropractor.

Patient Name: ……

Signed: …… Date: ……

Clinic Fees:
Initial Consultation: £49 Adjustment visits: £37 Re-Exams: £10

CONSENT TO TREATMENT (Please sign after speaking with the chiropractor)

I hereby request and consent to the performance of chiropractic treatment of me by Dr Gavin Sinclair / Dr Dara Tyrell / Dr Ryan Copleston or any other chiropractor working in this clinic authorised by Principal Chiropractor, Dr Gavin Sinclair.

I have had the opportunity to discuss with the chiropractor the nature and purpose of the chiropractic treatment and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some potential risk factors. I do not expect the chiropractor to be able to anticipate and explain all risks and complications and I wish to rely on the chiropractor to exercise judgement during the course of the procedure, which the chiropractor feels at the time, based upon the facts then known, and is in my best interests.

Personal Information

I understand that to provide me with chiropractic care and services, Wishaw Chiropractic will collect some applicable personal information about me. I agree to Wishaw Chiropractic collecting and using personal information about me and I understand that they will store and record my data in accordance with the Data Protection Act 1998.

Signed:
……
(Patient)
Signed:
……
(Chiropractor)

CHILD CONSENT

I hereby give my consent for my child …… to be treated by the chiropractor using chiropractic methods as seen fit.

Parent/ Guardian: Signed:
…… ……
(Print name) (Signature)

Date: ……