

# Premiere Health Care

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## INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am a legally responsible) by the doctor or his associates, affiliated with Premiere Health Care.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or associates, affiliated with Premiere Health Care to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guardian Signature

### Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an X-ray can be hazardous to an unborn child.

Date of last menstrual cycle:

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date