DR. DAVID W. SCHLINGLOFF
CHIROPRACTIC PHYSICIAN
96 REINMAN ROAD
WARREN, NJ 07059
(908) 754-9580

INFORMED CONSENT TO CHIROPRACTIC CARE

Patient: Please discuss any questions or concerns with the doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, possibly including various types of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor the purpose and benefits of the treatment that will be given to me. Alternatives to treatment have been reviewed.

I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the doctor's treatment.

Signature of Patient______________________________ Date________________

Signature of Parent/Guardian_____________________ Date__________________
(if patient is a minor)

Doctor's Signature_______________________________ Date_________________