

## CONSENT FOR TREATMENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

All patients in the State Of Georgia are required to approve of all services rendered by their doctor before any services are performed. Refusal to comply with Georgia Law releases your doctor of all liabilities and his/her right to refuse treatment.

I, \_\_\_\_\_, hereby request and give consent to my doctor to perform all necessary chiropractic examinations, adjustments, therapy, rehabilitation, and medical diagnostic x-rays. I understand that my doctor will consult with me before any procedures are performed, at which time, I will give him permission to perform all necessary procedures to treat my condition.

I understand that during my treatment that care may be rendered by other doctors at Horizon Health Care Group. I understand that I will be made aware of any such circumstances before being treated.

I understand that I have any opportunity to discuss with the doctor and/or with the office manager, the nature and purpose of my chiropractic care before any treatment is rendered.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_