Claim#: ______________________________
P.O. Box 23955, Federal Way, WA 98093
Phone: (253) 632-5320 Fax: (253) 214-7444
www.AGLAchiro.com

INFORMED CONSENT

FOR TREATMENT OF MINOR CHILD

I understand that chiropractic care consists of specific adjustments of the spine and other joints of the body that are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy, rehabilitative procedures, and/or therapeutic massage may be included. I have been informed that it is not uncommon that patients have some increased discomfort after chiropractic care. If that happens, I will apply ice to the area and rest it. In the event that I am out of town, or unable to contact Dr. Buclaw, I may contact my primary physician or present myself to an urgent care center/emergency room. I have had an opportunity to discuss with Dr. Buclaw, and/or other office personnel, the nature and purpose of chiropractic health care and understand that results are not guaranteed. I also understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, fractures and strokes. I do not expect the doctor to be able to anticipate and explain all risks and potential complications and I wish to rely on him to exercise judgment during the course of treatment which he feels is appropriate at the time, based on the facts then known, and that is in my best interests. If during the course of care he or his staff members encounter non-chiropractic or unusual findings, they will advise me of those findings and recommend that I seek the service of another health care provider. I hereby request and consent to the performance of chiropractic health care, including adjustments and various modes of physical therapy and, if necessary, diagnostic x-rays, on me by Dr. Buclaw and staff. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

I, ____ *(Print Name)* being the parent or legal guardian of ____________________________________ *(Print Name)* have read and fully understand the Informed Consent as written above and hereby authorize Dr. Robert E. Buclaw III, and whomever he may designate as his assistants to perform chiropractic evaluation(s), adjustment(s), treatment(s),as they deem necessary on my son/daughter listed above:

____________________ ____

Date Parent's Signature

____

Witness Signature