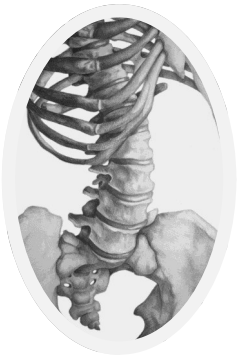

MIQUELI CHIROPRACTIC & MASSAGE THERAPY
910 16TH ST STE 221 DENVER, CO 80202 o 303-573-0984

CONSENT FOR CHIROPRACTIC CARE

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I have read the above paragraph. I understand the information provided. All questions I have about this information has been answered to my satisfaction.

Having this knowledge, I knowingly authorize Miqueli Chiropractic & Massage Therapy to proceed with chiropractic care and treatment.

Patient Signature _____ Date _____

Parental Consent for Minor Patient

Patient Name _____

Patient Age _____ DOB _____

Printed name of person authorized to sign for

Patient _____

Signature _____

Relationship to Patient _____