theCENTER
for orthopedic and athletic injuries
a chiropractic corporation

Frank Amato, DC, DABCO
Clinic Owner
Chiropractic Orthopedist, ART Certified

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic and physical therapists who now or in the future work at this office

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and are informed that in the practice of chiropractic treatments, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. These risks are rare and I do not expect the doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

Doctor's Name: Frank Amato, DC, DABCO

Patient"s Name Printed: _____

Patient Signature: _____ Date: _____

Legal Guardian's Name Printed: _____

Legal Guardian Signature: _____ Date: _____

Witness Name Printed: _____

Witness Signature: _____ Date: _____