Shell Chiropractic
& Wellness Center
a natural approach to a healthier you
JUNE M. SHELL, DC

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INFORMED CONSENT

I certify that I have had the opportunity to discuss, with June M. Shell, doctor of chiropractic, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed, and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment including, but not limited to factures, disc injuries, strokes, dislocations and sprains.

I also understand that Dr. Shell, who has explained all of these things to me, is not expected to be able to anticipate and explain all risks and complications which may arise. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions. Options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition)s) and for any future condition(s) for which I seek treatment.

PATIENT NAME (PLEASE PRINT)

WITNESS'S NAME (PLEASE PRINT)

PATIENT'S SIGNATURE

WITNESS SIGNATURE

DATE

DATE

☐ PATIENT'S REPRSENTATIVE (If patient is a minor)

☐ TRANSLATOR