SOPHIA A. ARGEROPOULOS, D.C., P.C.
9 Roosevelt Avenue
Port Jefferson Station, N.Y. 11776
631.473.8182

Date:_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of Chiropractic Adjustments and other Chiropractic procedures, including various modes of Physical Therapy and diagnostic imagining, on me or the patient named below for whom I am legally responsible, by DR. SOPHIA A. ARGEROPOULOS who is a licensed Doctor of Chiropractic and/or anyone working in this office authorized by Dr. Argeropoulos.

I have had an opportunity to discuss with the Dr. Argeropoulos and/or with other office personnel, the nature and purpose of Chiropractic care and any other procedures. I understand the results are not guaranteed.

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

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about it's content, and by signing below I agree to the treatment recommended by my Chiropractor. I intend this consent form to cover the entire course of treatment for my present condition(s) and any other condition(s) for which I seek treatment at this facility.

Patient's name:_____

Signature of Patient or Legal Representative:_____
(Revised 09/2017-7)