

# Patient Consent For Treatment

I, the undersigned, voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending chiropractic physician, and it is the responsibility of any staff in the employment of said physician to carry out any instructions or orders given appertaining to my care.

Initial: \_\_\_\_\_

I understand that there are potential risks associated with treatment and diagnostic procedures and that to the greatest extent reasonable, those risks that are relevant to my condition will be disclosed to me prior to the performance of those procedures.

Initial: \_\_\_\_\_

I further understand that if I fail to disclose to the treating physician or his/her staff, any details of my medical history, including but not limited to prior treatments, surgeries, medications, previous adverse events, pregnancies, etc., that I am solely responsible for any unwanted or adverse outcomes that may result from said diagnostic procedures or treatments.

Initial: \_\_\_\_\_

Furthermore, I understand that it is my responsibility to disclose to my treating physician or his/her staff, any ongoing or new/recent medical history, in order for him/her to determine the suitability of any treatments that I am or will be receiving.

Initial: \_\_\_\_\_

If you understand and accept the foregoing, please sign on the line provided below:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Name of Minor Child (if applicable): \_\_\_\_\_

Chiropractor On Wheels, LLC  
808 High Mountain Rd Suite 201-A, Franklin Lakes NJ 07417 • Phone: (551) 486-6143

Robert Press, MS, DC  
NJ Lic.#: 38MC00695500

Erik Geleta, DC  
NJ Lic #: 38MC00639000