MT HOPE
CHIROPRACTIC AND WELLNESS

1174 Mount Hope Ave
Rochester, NY 14620
p. 585.445.8584 e. mhcwny@gmail.com

Consent for care

I hereby Authorize the chiropractic physicians at Mt Hope chiropractic and Wellness and whomever they may designate as an assistant to administer treatment as is deemed necessary for my condition. I have the absolute right to refuse any treatment that I do not want. The risks associated with care have been described to me.

Signature _____ Date_____

Witnessed _____ Date_____

Consent to treat a minor

Parent/caretaker name_____ DOB___/___/____ Home Phone_____

Address _____ City _____ State____ Zip _____

Employer_____ Work Phone _____

Parent/caretaker name_____ DOB___/___/____ Home Phone _____

Address _____ City _____ State____ Zip _____

Employer_____ Work Phone _____

* I hereby authorize the chiropractors employed at Mt Hope chiropractic and wellness to evaluate and treat my son/daughter as the deem necessary

Signature _____ Date_____

Authorize for medical records

I Hereby authorize Mt Hope Chiropractic and Wellness to obtain any medical, surgical, or diagnostic imaging reports relevant to my treatment. I authorize Mt Hope Chiropractic and wellness to release my medical record to my insurance company to facilitate payment, as well as to other healthcare providers involved in my healthcare when applicable.

Signature _____ Date_____