

**RIVERA CHIROPRACTIC AND WELLNESS CENTER
2418 MARSH LANE, SUITE 100
CARROLLTON, TEXAS 75006
(972)478-8500**

AUTHORIZATION FOR TREATMENT

I, _____, by signing this form, am requesting and consenting to the diagnostic and therapeutic procedures which my include, but are not limited to physical examination, x-ray examination, laboratory analysis, medication, and physical therapy to be performed by Rivera Chiropractic and Wellness Center clinician and staff.

I hereby warrant that I have not been legally adjudged as incompetent. I understand that it is my right to determine the extent of my medical care, and that I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment.

I recognize that no guarantees have been or can be made regarding the likelihood of success or the outcome of any evaluation, treatment, test, procedure, or therapy performed by Dr. Rivera or his staff.

I hereby warrant that I have read and understand to my satisfaction all of the above.

Authorization of patient/Representative:

Patient Signature

Date

Representative, Parent, Guardian

Date

Representative's Capacity