MICHAEL S. HORNEY, D.C.
416 RT 25A
EAST SETAUKET N.Y. 11733
PH - 631-751-7700
FAX 631-751-7096

INFORMED CONSENT

I have received information about my condition and proposed chiropractic treatment program, as well as alternative courses of care, the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all healthcare, in the practice of chiropractic there are some rare risks to treatment, including but not limited to, muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I do not expect Dr. HORNEY to be able to anticipate or explain all risks and complications. I wish to rely on Dr. HORNEY to exercise his judgement during the course of the treatments which he feels at the time, based upon the facts then known, is in my best interests.

Dr. HORNEY has responded to all of my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content.

By signing below, I consent to chiropractic treatment.

X _____ X _____ _____

PRINT PATIENT NAME | SIGNATURE OF PATIENT | DATE

_____ _____ _____

PRINT PARENT/GUARDIAN | SIGNATURE PARENT/GUARDIAN | DATE

_____ _____ _____

PRINT WITNESS NAME | SIGNATURE OF WITNESS | DATE

_____ _____

DOCTOR'S INITIALS | DATE