**RUMEL LLANTADA, DC CCSP**

**5252 BALBOA AVENUE SUITE 701**

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**(858)384-6556**

**INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE**

**I understand that as part of my healthcare, this organization originates and maintains health** **records describing my health history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care and treatment.**

**I understand that I have the right to see and receive a copy of my health records.**

**I hereby request and consent to the performance of Chiropractic adjustments, physical examination, soft tissue procedures, physiotherapy and diagnostic x-rays. If warranted, on me should I elect to seek care from Dr. Llantada’s office. I consent and allow Dr. Llantada to evaluate and treat me on an emergency basis should I be in a condition where I am not able to authorize consent.**

**I understand, that as in the practice of medicine, there are some risks to treatment in the practice of Chiropractic care, including, but not limited to, sprains, disc injuries, dislocations, fractures and stroke (in extremely rare cases). I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor feels at the time, based on the facts then known, are in my best interests.**

**I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow Dr. Rumel Llantada to perform such. I intend this consent to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.**

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**Patient/ or Legal Representative Signature Date**