RCC Rossow Chiropractic Clinic

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Clinic Director
Dr. William N. Rossow
Doctor of Chiropractic

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AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient of this office hereby authorize ***Dr. William N. Rossow*** *(and whomever he may designate as his assistants) to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of the findings during the course of said treatment.*

I hereby certify that I have read and fully understand the above Authorization for Chiropractic treatment, the reasons why the above named treatment is considered necessary, its advantages and possible complications, if any as well as possible alternative modes of treatment, which were explained to me by ***Dr. William N. Rossow****.*

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

MISSED APPOINTMENTS

I understand that if I fail to appear on time for my apppointment as scheduled, I will be placed on a will-call list. (Will call refers to a list of patients who are called when an opening appears in the schedule.)

_____ / _____
SIGNATURE *DATE*

_____ / _____
WITNESS *DATE*