



CONSENT FOR TREATMENT

I do hereby consent to treatment of my condition by the staff of The Spine Center. I also certify that no guarantees or assurances have been made to me as to the results that may be obtained as a result of procedures, treatment and/or techniques used by The Spine Center. I further understand that while I am being assessed and/or treated at The Spine Center will not be held responsible for any injury sustained outside of its immediate physical premises.

_____ Date: _____

Patient's Signature

_____ Date: _____

Alternate Signature (if patient cannot sign)