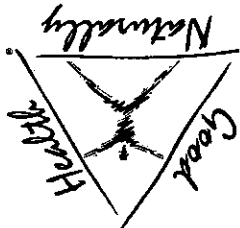


BARLEY FAMILY HEALTH CARE & REHABILITATION



CONSENT TO CHIROPRACTIC SERVICES

1. I, _____, AUTHORIZE THE PERFORMANCE UPON MYSELF OF THE FOLLOWING PROCEDURE(S):

(EXAMINATION, X-RAY, CHIROPRACTIC ADJUSTMENT)

2. I ALSO CONSENT TO THE PERFORMANCE OF OTHER DIAGNOSTIC AND THERAPEUTIC PROCEDURES IN ADDITION TO OR DIFFERENT FROM THOSE STATED ABOVE, WHETHER OR NOT ARISING FROM PRESENTLY UNKNOWN CONDITIONS, THAT THE ABOVE NAMED DOCTOR, ASSOCIATES, OR ASSISTANTS MAY CONSIDER NECESSARY OR ADVISABLE IN THE COURSE OF MY HEALTH CARE.

3. THE NATURE AND PURPOSE OF THE PROCEDURES, POSSIBLE ALTERNATIVES, THE RISKS INVOLVED, THE POSSIBLE CONSEQUENCES, AND THE POSSIBILITY OF COMPLICATIONS WILL BE EXPLAINED BY THE ABOVE NAMED DOCTOR, ASSOCIATES, OR ASSISTANTS.

4. I ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE OF THE RESULTS THAT MAY BE OBTAINED FROM THE PROCEDURE HAS BEEN GIVEN BY THE DOCTOR.

DATE: _____

SIGNED: _____

WITNESS: _____

RELATIONSHIP: _____

DR. JOSEPH P. SHERIDAN

DR. DENNIS A. BARLEY

DR. TERRY SOUCIE

ELAINE YOUNAN, PT.

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