Family Network Chiropractic, PC
79 Saint James Street, Suite 1
Kingston, NY 12401
(845) 338-3888

Open Room Consent and Authorization

I hereby give my consent and authorization to be treated in the open room with other patients. I understand that this room is utilized so that the doctor can keep a closer watch on each patient and so the patients can learn from the experiences of other patients; which all improves the experience and the quality of my own network chiropractic care.

I understand and give my consent and authorization for the doctor to ask questions relating to my care and my overall well-being and I will answer freely and of my own will, with full consent and authorization if I choose. In addition, I understand that I may elect at any time to not answer any questions, and/or to request to answer the doctor or ask a question in private. Other than this, I understand that if I ask the doctor a question in the open room, that I am giving my full consent and authorization for him to answer my question in the open room.

Patient Name (Printed) ____

Patient's/Responsible Party Signature: __________________________________

For Third Party Authorization, Relationship to Patient: ____________________

Date______________