



**Dr. Scott Rubin**  
**1500 MLK Jr. Street North**  
**St. Petersburg, FL 33704**  
**Phone: 727-822-1555 Fax 727-822.1777**

**Authorization for Chiropractic and / or Massage Treatment  
and Informed Consent**

I hereby authorize the above named doctor / clinic to administer treatment to me and perform chiropractic manipulation, physical therapy and / or massage treatment.

I also authorize additional procedures as the above named doctor / clinic may consider necessary on the basis of findings and determinations made during the course of treatment.

I certify that I have read and fully understand the above Authorization for Chiropractic and / or Massage Treatment. I also certify that I understand, although rare, there are inherent risks and possible complications of chiropractic treatment including, but not limited to, stroke and even death.

\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Guardian or Patient's Legal Representative

\_\_\_\_\_  
Signature

