

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Printed name of patient

Signature of Patient

Date

Signature of patient's representative (if minor)

Date