INFORMED CONSENT

We want you to be informed about the care in which you may receive, including risks and benefits. This information is given so that you may be knowledgeable about your choice to consent to chiropractic care.

Risks & Benefits of Care:

I understand and am informed that in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, and sprains. In the majority of cases, chiropractic care offers multiple benefits including the relief of neck pain, headaches and low back pain.

Alternative Treatments including risks and benefits:

Alternative treatments include, but may not be limited to massage therapy, physical therapy, medication, supplementation or surgery. The risks involved with these alternative treatments should be discussed with practitioners within the relative field. Chiropractic care offers a non-invasive, natural treatment of vertebral misalignments.

Risks of no treatment at all:

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise implied or otherwise, of a cure for any symptoms, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on the doctor exercise professional judgement during the course of any procedure, which she feels at the time to be in the best interest. Neither the practice of chiropractic nor medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgement and expertise in working with like cases.

I understand and have (or had read to me) the risks listed above. I acknowledge that I had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my chiropractor. I understand that results are not guaranteed. I intend for 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.

Patient Name (PRINT) _____

Patient Signature _____ Date: ___/___/___

(If patient is a minor, consent must be signed by parent or official guardian)

Parent, Guardian or Legal Representative (PRINT) _____

Parent, Guardian or Legal Representative Signature _____ Date: ___/___/___