

Informed Consent to Chiropractic Adjustment and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I've had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulations and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. These complications are rare. I may feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the doctor's attention, it is my responsibility to inform him.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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.

Consent to Treat a Minor (Required for all patients under 18 years old)

I hereby request and authorize this clinic to perform diagnostic tests and render treatment to my minor (son/daughter/other)_____. This authorization extends to all doctors and staff members and includes radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor named above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or parent is not required. If my authority to select and authorize this care should be revoked or modified in any way I will immediately notify this office. I also consent to the minor listed above to be treated without me present in the office.

ALL PATIENTS:

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read [] or have had read to me [] the above explanation of the examination and treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the benefits, risks, and alternatives, I hereby give my consent to all examination, testing, and treatment described above.

Patients Name: _____

Doctors Name: Dr. Mario Garcia, DC

Signature: _____

Signature: _____

Dated: _____

Dated: _____

Signature of Parent or Guardian (if the patient is a minor) _____