Anderson Chiropractic & Sports Clinic
Chad J Anderson D.C.

Disclosure & Consent to treat: Chiropractic Adjustments and care

TO THE PATIENT: You have a right as a patient to be informed about your condition the recommended Chiropractic adjustments and other Chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks, and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent for the procedure(s).

I hereby request and consent to the performance of Chiropractic adjustments, and other Chiropractic procedures, including, but not limited to, various modes of physiotherapy, x-rays, heel lifts, orthotics on me, (or the patient named below, for whom I am legally responsible) by Chad J. Anderson D.C. or a licensed Chiropractor if Dr. Anderson is out of the office, and they are filling in.

I have the opportunity to discuss with Dr. Anderson or the doctor working as his backup in the office while Dr. Anderson is out of the office about my diagnosis, the nature and purpose of the chiropractic adjustments and the other procedures and alternatives. I understand and am informed that, in the practice of Chiropractic there are some risks to examination and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain, or no improvement of the current symptoms, or pain. **Other treatment options which could be considered** may include the following:
Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. *Surgery*, in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise clinical judgment during the course of the procedure which the doctor feels at the time, based on the facts made known to him by me making full disclosure of the facts to the best of my ability. That is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results from the intended treatment.

I have read, or asked to have read to me, the above consent, I have also had the opportunity to ask questions, and all of my questions have been answered fully and to my satisfaction. By signing below, I consent to the treatment plan that the doctor has laid out for me. I intend that 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 for.

To be completed by the patient:

_____
Print Name

_____ _____/_____/_____
Signature of Patient DATE SIGNED by PATIENT or REP

_____ _____/_____/_____
Signature of Doctor's Staff DATE SIGNED by DOCTOR'S STAFF

_____
Doctor's Signature

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