Patient Consent Authorization

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask a question before you sign if there is anything that is unclear.

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

As with any healthcare procedure, there are certain complications, which may arise during chiropractic adjustment and therapy. These complications include: muscle soreness, joint stiffness, disc injuries, muscle strain, rib cage strains and separations, and fractures. Some treatments have been associated with injuries to the arteries in the neck leading or contributing to serious complications including stroke. Fractures are very rare occurrences and generally result from some underlying weakness of the bone, which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

As your doctor, I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or the patient or to a family member or employer of the patient for all of a part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's Printed Name: _____

Patient's Signature: _____

Other than patient, print name and relationship: _____

Witness: _____

If Applicable, Verification of Non-Pregnancy

Date: _____ Date of L.M.P. : _____

By my signature on this form I do herby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.