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INFORMED CHIROPRACTIC CONSENT FORM

Name: _____ **Date:** _____

Informed Consent to Chiropractic

I understand and am informed that in the practice of **chiropractic** there are some risks to treatment, including but not limited to, muscle strain, ligamentous sprain and rib fracture following spinal adjustments or manipulation. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely rare. There have been rare reported cases of disc injuries following neck or low back spinal adjustment or manipulation; however, scientific study has not supported that such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

INITIALS _____

Informed Consent to Acupuncture

I understand and am informed that in the practice of **acupuncture** there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles. I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Female patients: I fully understand that in the case of pregnancy, there is a small risk of causing fetal distress with acupuncture treatment(s).

INITIALS _____

Informed Consent to Soft Tissue Therapy

I understand and am informed that in the practice of soft tissue therapy there are some risks to treatment, including, but not limited to, muscle strain, ligamentous sprain, bruising, minor pain or soreness, nausea, and fainting.

INITIALS _____

Privacy Policy

Our privacy policy is in accordance with the Personal Information Protection and Electronic Documents Act. Detailed copies of our privacy policy can me made available upon request.

Cancellation Policy

If you are unable to keep your scheduled appointment and 24 hours notice is not provided, you are responsible for the full fee of your visit.

INITIALS _____

Patient Signature

I (please print name), _____, have read the above and understand that I am personally responsible for all services rendered. By signing below I agree to all fees above and any additional fees that may apply to the purchase of products or adjunctive therapeutic devices. Increases in fees may apply at the beginning of each new calendar year. I acknowledge that I have read this consent and have had the opportunity to discuss the nature and purpose of chiropractic treatment recommendations and the contents of this Consent. I consent to the chiropractic treatment recommended to me by my chiropractor. I intend this consent to apply to all my present and future chiropractic care.

_____ _____
SIGNATURE (guardian if under 18) DATE