Treatment Consent Form

Name: _____ **Date:** _____
Last **First** **Middle**

_____
Patient ID No.

Treatment Disclosure Information

Chiropractic examination and therapeutic procedures (including spinal and extremity adjustments, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries of the neck which may be associated with stroke and serious neurological impairment, injuries to the spinal discs, and fractures. Serious complications are estimated to be in the range of 0.5 to 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the lower back. Additional information on side-effects, complications, and effectiveness of chiropractic adjustments are available upon request.

Treatment Agreement Statement

After examination by the Doctor my treatment recommendations will be explained. I reserve the right to refuse care at any time. By signing below, I state I have read, or have had read to me, the above. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. I consent to treatment at this office and I have the right to revoke this consent, in writing, at any time.

Treatment Consent Signatures

Patient's signature:	**Date:**
If minor, parent's signature:	**Date:**
Doctor's signature:	**Date:**

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