***LEGAL NOTICE/DISCLAIMER***

***The information contained in this document does not establish a standard of care, nor does it constitute legal advice. The information is for general informational purposes only and is written from a risk management perspective to aid in reducing professional liability exposure. Please review this document for applicability to your specific practice. You are encouraged to consult with your personal attorney for legal advice, as specific legal requirements may vary from state to state.***

# Informed Consent for Chiropractic Treatment

***TO THE PATIENT:*** *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that as with any health care procedure, there are some possible risks to chiropractic treatment including, but not limited to:

* Stiffness/soreness 🞎 Increased symptoms or pain
* Broken bones 🞎 No improvement of symptoms or pain
* Dislocations 🞎 Bruising
* Sprains/strains 🞎 Injury to intervertebral discs, nerves, or spinal cord
* Burns or frostbite 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Worsening/aggravation of spinal conditions 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In rare cases there have been reported complications of arterial dissection leading to a stroke when a patient receives a cervical adjustment. Symptoms may include trouble with balance or coordination, dizziness, hearing loss, double vision, neck pain, severe headaches, slurred speech, or death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

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*To be completed by the patient: To be completed by the patient’s representative:*

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print name print name of patient

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signature of patient print name of patient’s representative

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date signed signature of patient’s representative

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relationship/authority of patient’s representative

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date signed

*To be completed by doctor:*

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signature of doctor

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translated by (print name) date