Mueller Chiropractic

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Craig A. Mueller, DC   Steven Tinlin, DC

INFORMED CONSENT TO CHIROPRACTIC CARE and ADMINISTRATIVE FEES

I hereby request and consent to the performance of Medical treatment and assessment, Chiropractic adjustments and rehabilitation procedures performed at Mueller Chiropractic & Physical Medicine and performed by the doctors listed above. I understand that treatment methods in this office vary from doctor to doctor and are based on my condition. I represent that I have come here for care at my own direction and by my own choice.

I have had the opportunity to discuss with the Doctors and /or with other office personnel the purpose and benefits of the services recommended in my case. I have had the opportunity to discuss any short or long-term consequences, favorable or unfavorable, to any therapy, including Class IV laser therapy, applied to me. I have had the opportunity to discuss alternative treatment of my condition and have personally decided that the care being offered here is reasonable as presented.

Though all therapies provided at MCPM, including Chiropractic adjustments and Class IV laser therapy to my brain and nervous system, are intended to improve one's health and vitality, I understand and am informed by means of this document that some risks exist when any treatment is intended to change bodily function. Risks may include (but are not limited to) fractures, disc injuries, dislocations, sprains and possible, and rarely strokes. Some treatments to ill or injured person may exceed the metabolic capacity of an individual. Every effort is made to insure the person is capable to receive what ever care is provided. I realize I have had ample opportunity to ask any doctor on this staff to outline potential risk in my case based on the findings of my evaluation.

In the course of my care or simply for health screening and examination, Infrared Imaging, not an anatomical test may be used. In that process any reference to anatomy refers to the thermal emission from the skin overlying that anatomy. Comments made in impressions or conclusion are speculative and not intended to rise to the level of a "diagnosis" but to provide insight into functional risk indicators that may aid the primary care physician in clinical decision making.

I understand that rehabilitation to brain, brain stem, spinal cord, muscles, joints, tendons and nerves as well as interpretation of thermal patterns on infrared imaging is not an exact science. I understand that reputable, well trained practitioners cannot fully guarantee results. No guarantee or assurance has been made by anyone at MCPM, nor is treatment by one doctor a reflection on or the responsibility of the others. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I hereby release, do not hold responsible and waive any liability concerning the diagnosis and or treatment of my condition from the doctors at Mueller Chiropractic & Physical Medicine. I hereby consent to the proposed treatment recommended on my report of findings and affirm that I have made full disclosure regarding all information that would influence my care or place the specific treating doctor at risk. I agree to hold the non-treating doctors harmless for my care.

Signature of Patient: ____ Date:

Signature of Parent: ____ Date:
(or Guardian/Spouse)

Witness Signature: ____ Date: