FamilyHealthProfessionals
HELENSVALE
Southport Chiropractic CLINIC

Consent To Chiropractic Care

When performed by a qualified Chiropractor, spinal manipulation is effective and safe method of treatment for many conditions. There are, however risks associated with any treatment and we are required to inform you of these, even though there has never been a serious injury in our clinic. Please read the following carefully, and note down any questions you may have.

I hereby request and consent to the performance of Chiropractic treatment on me by Dr Luke Hennessy Bsc. M Chiro and/or any other Chiropractor practicing in this clinic, authorised by Dr Hennessy.

I understand, and I am informed that, as in the practice of medicine, in the practice of Chiropractic there are some very slight risks to treatment, including, but not limited to, muscle and joint soreness, muscle strains, joint sprains, fractures, disc injuries, strokes and stroke-like episodes.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the treatment, which the doctor feels at the time, based upon the facts then known, is in my best interests.

I am aware that this clinic works on an open door policy and that I can request the presence of a Chiropractic Assistant at any stage of my care.

I understand that there are no video or audio recording devices used within the practice and that neither I, nor any persons accompanying me, are permitted to use video or audio recording devices whilst in the practice unless prior approval has been granted by the Chiropractor.

I have read the above, and I have also had the opportunity to ask questions about its content.

I intend this consent form to cover all treatment for which I present. I understand that I can withdraw my consent at any time.

Patient Name: _____ Patient Signature: _____ Date: ____/____/20____

I am aware that my initial consultation is free, with no obligation to progress to a comprehensive examination and or treatment. However, I understand that I am responsible for payment of fees incurred on the day of service if I choose to proceed to the examination. I also understand that any “third party” claims through Medicare (EPC), Department of Veterans’ Affairs and or Workcover will be my responsibility if the “third party” rejects the claim.

Patient Name: _____ Patient Signature: _____ Date: ____/____/20____