Integrity Chiropractic
Live Better Naturally

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I WISH TO BE CONTACTED IN THE FOLLOWING MANNER

(check all that apply)

( ) **Home** Telephone (___) _____.
( ) O.K. to leave a detailed message
( ) Leave message call back number only

( ) **Work** Telephone (___) _____.
( ) O.K. to leave a detailed message
( ) Leave message call back number only

( ) **Cell** Phone (___) _____.
( ) O.K. to leave a detailed message
( ) Leave message call back number only

PATIENT INFORMED CONSENT

The practice of chiropractic can include exams, diagnostic testing and treatment. My care may involve the making of recommendations based upon facts known to the doctor at this time. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, acupressure, nutritional and/or physical therapy, and rehabilitation procedures, etc. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy-C.M.T.) Because health care is not an exact science, health care professionals are required to give me, the patient, advanced notice of any care risks. All health care procedures have some risks.

With chiropractic manipulative therapy, the inherent limited risks include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome (V.A.S), stroke, etc. They occur seldom enough to contraindicate care, but should be considered in my informed decision to receive chiropractic care. The chances of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments to 1 per 1,000,000 treatments. This is an undesirable result, but it does not necessarily indicate an error in clinical judgment. Appropriate tests will be performed to identify if I may be susceptible to these risks, and I will be notified, in that case.

I have read (or have had read to me) the above information. I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of care, the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment to my satisfaction. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of my treatments which she/he feels at the time, based upon the facts then known, are in my best interest**.** I acknowledge that no guarantee of results or cure has been made to me, the patient, from this office. By signing below, I agree to have the recommended chiropractic care performed.

Signature: _____ ( ) Adult Patient ( ) Parent or Guardian ( ) Spouse

Print Name: _____ **Date**_____ **Witness Initial:** _____