INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, potentially including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below whether they are signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks or complications. I wish to rely on the doctor to exercise good judgment during my course of care. I expect the doctor to perform procedures which he/she feels, at the time and based upon the facts then known, are in my best interest.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatory, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Arensdorf Chiropractic
Dr. Ray Arensdorf

PATIENT SIGNATURE_____ DATE_____

GARDIAN/PARENT REPRESENTATIVE_____
(Provide name and relationship if signing for patient)