Informed Consent

You have the right to be informed about your condition and the possible options for treatment. This includes knowing the risks and benefits related to each treatment option. This information will help you make an informed decision about whether or not to follow the recommended care.

When a patient seeks chiropractic care it is important for doctor and patient to be working towards the same goal. Chiropractors focus on finding and removing subluxations. Subluxations are misalignments of joints in the body that prevent normal movement. This can change nerve function and hinder the body's natural ability to heal. We remove these subluxations through the use of adjustments. An adjustment is a specific thrust into the misaligned joint that helps restore normal motion. This allows the nervous system to work better at keeping you healthy.

In addition to the many benefits of chiropractic care, there are also some risks. These risks should be considered when making the decision to receive chiropractic care. All health care procedures have some risk associated with them. Symptoms you may feel after starting care include muscle spasm, bruising, nausea, dizziness, fatigue and soreness. These should subside after your first 3-5 visits. Severe risks such as nerve injury, fracture, and stroke are very rare but can occur. The technique used in this office is very gentle and greatly decreases these risks. There is no guarantee that the treatment will provide the expected or desired outcomes. Your lifestyle, including diet, exercise and stress level, will affect your results.

If, at any time, you have questions or concerns regarding your treatment please contact our office. The doctor will be happy to discuss them with you.

Consent for Chiropractic Care

I have read and understand the purpose of chiropractic care and the potential risks involved. I also understand that the doctor does not guarantee my response to care. Other treatment options have been explained to me and my questions about this consent form have been addressed.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND WHAT I HAVE READ. I CONFIRM THAT ALL MY QUESTIONS HAVE BEEN ANSWERED.

I CONSENT TO RECEIVE THE CHIROPRACTIC CARE DEEMED NECESSARY BY THE DOCTOR.

DATED THIS _____ DAY OF _____, 20_____, CHESTERFIELD, VA

_____ _____

Print Patient Name Patient Signature

_____ _____

Print Doctor Name Doctor Signature

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person authorized to sign for Patient:

_____

Signature: _____

Relationship to Patient: _____