“Informed Consent to Chiropractic Adjustments, Care and Physical Therapy”

Please initial each box below

_____

Patient Name (Please Print)

Patient
Initials

☐ I hereby request and consent to the performance of chiropractic adjustments, physical therapy and other procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic, and therapy assistants in this office and/or anyone working in this clinic authorized by the doctor.

☐ I further understand and am informed that, as in all healthcare, in the practice of medicine/chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains and sprains, disc injuries, stroke, and fracture. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctors to exercise judgment during the course of the procedure that the doctor feels at the time, based on the facts then known, and is in my best interest.

☐ I have been informed that it is not uncommon to experience some increased discomfort after physical therapy and chiropractic manipulation. If that happens, I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms, I can call the number below 24 hours a day for emergency attention. If I am out of town or unable to contact the doctor I can present myself to an emergency room.

☐ If any test were performed outside this office (laboratory or other diagnostic procedures), I understand that the doctor will notify me of the results at my next scheduled appointment or when the reports become available.

☐ I am aware that Elite Health and Wellness is not responsible for any damage or loss to my personal belonging. This includes but is not limited to clothing, jewelry, glasses, shoes, purses or wallets. We advise you to not wear or bring into the office any items that could easily be damaged during your treatments.

☐ I have had the opportunity to discuss the nature and purpose of the chiropractic treatment, physical therapy and other procedures with the doctor of chiropractic and/or with other office or clinical personnel. I understand that results are not guaranteed.

☐ I have read the above consent with the doctor as indicated by my initial. 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 injured condition for which I seek treatment at Elite Health and Wellness.

_____ ____/_____/_____ _____ _____/_____/_____
Patient Date Parent or Guardian Date

_____ _____ _____/_____/_____
Physician name Physician Signature Date