

Henderson Chiropractic & Sports Rehab Clinic

INFORMED CONSENT TO CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic treatments and other chiropractic procedures, including various modes of physical modalities and diagnostic X-rays, 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 Doctor 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, including those working at the Clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with Dr. Henderson and/or with other office personnel the nature and purpose of chiropractic treatments and other procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of Chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains, and these are rarely encountered. I do not expect the Doctor to be able to anticipate and explain all risks and complications. I wish to rely on the Doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest. 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(s) and for any future condition(s) for which I seek treatment.

All charges incurred at *Henderson Chiropractic & Sports Rehab Clinic* are my total responsibility regardless of payment by me, my insurance company, or other person's responsible for my account, and regardless of satisfaction of care. If this account is placed with an attorney or collections agency for collection, I am aware of having additional fees added. If litigation pursues, I also understand I will be responsible for additional court cost or attorney fees.

Patient's Signature: _____ Date: _____

Patient's Representative's Signature: _____

About Your Care

Chiropractic provides three types of care.

Initial Intensive Care: This includes relief and symptomatic care. The goal is to eliminate or reduce your major complaints as well as stabilize your condition(s). This requires frequent visits (several times per week) that may continue for weeks to months.

Rehabilitative Care: This rehabilitative care is designed to provide optimum healing of the function(s) of the spine, associate tissues and organ systems. This helps prevent the original problem from returning. Frequency of visits varies, but it is less than Initial Intensive Care.

Wellness/Maintenance Care: This is designed to maintain your improved health and spinal function. The decision to begin this care is made once it is determined your condition(s) have recovered they best it can from the possible permanent damage that may have occurred prior to care. Visit frequency is based on the needs of the individual and is less than Rehabilitative Care.

All of these options will be explained at your Report of Findings, then you will be able to begin a course of care that best fits your health goals.

Questions: Do not hesitate to ask questions, we want you to be informed. Proper communication is an absolute necessity. Our primary concern is to help you attain you optimum health.

Acknowledgment: I have read and fully understand the above statements.

Patient's Signature: _____ Date: _____

Patient's Representative's Signature: _____