CONSENT FOR CHIROPRACTIC SERVICES

EXAMINATIONS AND TREATMENT

PATIENT NAME:_____ DATE:_____

Please read this entire document prior to signing it. It is important that you understand all the information. Kindly ask questions if there is anything that you are unclear about.

RISKS:

As with any health care procedure, analysis, exam, or treatment, there are certain complications that are possible. The same is true for Chiropractic Physician services. These may include but are not limited to: fractures, dislocations disc injury, dislocation strains, sprains, separations, stroke, nerve injuries, etc. I make every reasonable effort to screen for all possible contraindications for care during the exam process. If you have any conditions that are significant, and not yet brought to my attention, please inform us today, so that we may understand all aspects of your health status prior to beginning care at my office.

PROBABILITY OF RISK:

All complications related to Chiropractic Physician services are exceedingly RARE. Chiropractic physician malpractice insurance rates are the lowest in the country of any physician provider group. Stroke injuries are the subject of great disagreement. Incidence is rated between one in five million to one in one million events. Also, the majority of cases on record were caused by non-chiropractic physician providers performing neck adjustments for which they were not properly trained.

AVAILABILITY OF OTHER TREATMENT OPTIONS:

Other treatment options that you may want to consider prior to beginning care are:

1- Self administered over the counter medications and rest
2- Medical care with prescription drugs
3- Hospitalization
4- Surgery
5- Do nothing

Note: All choices will have some level of danger and risk related. If you are still unclear of your options, we can discuss them further prior to initiating care, or you can consult your primary care physician.

DO NOT SIGN UNLESS YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION.

I have read (or it was read to me), the above information. I have discussed with Dr. Post any questions that I had and they have been addressed to my satisfaction. By signing below I state that I have decided to commence care with Dr. Post. Having been informed of the risks, I hereby give my consent to his care and treatment.

Patient's Name: _____

Dr.'s Name: _____

Patient's Signature: _____

Dr.'s Signature _____

Guardian Signature: _____

Guardian Name: _____