FREEMAN CHIROPRACTIC CLINIC

# Informed Consent to Treat

I hereby request and consent to the performance of chiropractic procedures, including but not limited to, chiropractic adjustments, various modes of physiotherapy, diagnostic x rays, and any supportive therapy on myself (or the patient listed below that I am legally responsible for) by the Doctors of Chiropractic listed below, their partners, associates, and their support staff.

I understand and am informed that, as with all healthcare procedures, results are not guaranteed and there is no promise for a cure. I further understand and am informed that, as with all forms of healthcare, there are some risks to treatment including but not limited to, muscle spasms, aggravating or temporary increase in symptoms, possible lack of improvement in symptoms, fractures, disc injuries, dislocations, strains and sprains. I do not expect the Doctor or his staff to be able to anticipate and explain every risk or complication, and I will rely on the Doctor and his staff to exercise judgement throughout the course of my treatment based on the known facts and what is in my best interests.

I further understand that Chiropractic adjustments and supportive therapy is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all healthcare procedures, results are not guaranteed and there is no promise to cure. Accordingly, I understand all payments for treatments are final and no refunds will be issued.

I further understand that there may be other options available for my condition. I understand I have the right to a second opinion should I have any concerns as to the course of treatment recommended or the diagnosis of my condition.

I have read or have been read the above informed consent. I have been given the opportunity to ask questions about its content and by signing below I agree to the procedures recommended by the Doctor of Chiropractic, their associates and staff. I intend for this consent to cover the entire course of treatment for this condition and any future treatment I seek at this clinic.

**Name of Patient**_____

**Signature of Patient/ Guardian**_____

**Date**_____

**Doctor Name**_____

**Doctor Signature**_____

**Date**_____