AmazingLife
Chiropractic and Wellness

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Informed Consent to Treatment

INIT_____ I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic and/or massage carries some risks to treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are infrequent reported cases of burns or skin irritation or bruising in association with the use of hot/cold packs offered by some Doctors of Chiropractic or Massage Therapists.

c) There are reported cases of strokes associated with visits to Medical Doctors and Doctors of Chiropractic. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting Medical Doctors and Doctors of Chiropractic when they are in early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

INIT_____ I do not expect the Doctor of Chiropractic nor Massage Therapist to be able to anticipate and explain all risks and complications. Further, I wish to rely on the Provider to exercise judgment during the course of the procedure which the they feel are in my best interests at the time, based upon the facts then known. The Provider, of course, will not give a treatment, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known whatever he/she is suffering from, such as: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Provider. **I understand that results are not guaranteed.**

INIT_____ I, hereby request and consent to the performance of chiropractic adjustment and other therapeutic procedures, including various modes of manual therapy, massage, and diagnostic x-rays on myself (or on the individual named below, for whom I am legally responsible) by ***Amazing Life Chiropractic & Wellness***, and/or other licensed Provider who now, or in the future, treats me while employed by/working/associated with, or serving as back-up for ***Amazing Life Chiropractic & Wellness***.

INIT_____ I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

INIT_____ I understand and agree that upon any cancelation of Massage within 24 hours of the appointment there will be a **$40.00 cancelation fee**, this fee is not covered by insurance and will automatically be charged to my available payment method on my account.

I acknowledge that I have read or have had read to me, this consent. I have also had the opportunity to ask questions about its content. 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 future condition(s) for which I seek treatment.

Patient Name (print)**:** ___________________________________ Date: ________________

Patient Signature (or Guardian Signature and Name): ______________________________________

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR, PHYSICALLY OR LEAGALLY INCAPACITATED