



INFORMED CONSENT FOR CHIROPRACTIC CARE

Patient: _____ Parent/Guardian: _____

I hereby request and consent to appropriate chiropractic case management for me (or for the person named above, for whom I am legally responsible) provided by Life Adjusted Chiropractors.

Patient initial

- 1. The purpose of chiropractic care is to optimize health by facilitating neurological and biomechanical integrity, which allows maximum expression of the body's innate recuperative abilities.
2. I understand that chiropractic services will be provided by licensed doctors of chiropractic who are employed by Life Adjusted.
3. Life Adjusted uses various chiropractic methods that are taught in accredited chiropractic colleges and seminars. The appropriate techniques will be selected for my care based upon standard professional protocols. My diagnosis and all proposed procedures will be explained to me and implemented only with my approval. Alternative and adjunctive recommendations for health promotion will be discussed with me.
4. Chiropractic adjustments are exceedingly safe when applied properly. However, I understand there are some risks to care including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain every risk and complication, but I will rely on the doctor's best judgment to protect my best interests. No guarantees of cure have been implied or given.
5. A small force is introduced into the spine during the chiropractic adjustment that may lead to temporary musculoskeletal discomfort. This is usually minor and transient.
6. The case doctor will discuss any further risks inherent for my particular case as necessary and will document this discussion in my case record. Any questions or concerns that I may have will be addressed at this time. I understand that I am an active participant in my chiropractic care, and that I am encouraged to bring up questions or express any concerns.
7. I give my permission to Life Adjusted staff to communicate by telephone, text, or by email regarding matters of chiropractic care, appointment reminders or scheduling.
8. Life Adjusted is compliant with all HIPAA regulations, and takes all reasonable precautions to safeguard your privacy in all matters. I understand that any concern I have regarding privacy and safety of my health information may be discussed with my case doctor.
9. I understand that my clinical data may be anonymously used for research purposes.
10. I am free to refuse care or withdraw my consent and discontinue care at any time.
11. By signing below, I affirm that I have read, or had read to me, this consent document, and I agree to its provisions. I intend this document to cover the entire course of care now and in the future.

_____/_____/_____ Would you like a copy Y/N
Patient/Parent/Guardian's Signature

_____/_____/_____
Case Doctor

Original Patient copy