Bullard Chiropractic Clinic

"For Proven Results You Can Feel"

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INFORMED CONSENT

After discussion with my Chiropractor, I hereby request and consent to chiropractic healthcare. Chiropractic healthcare incudes, but is not limited to physical examination, palpation, orthopedic tests, neurological tests, and x-ray examination as indicated. Chiropractic adjustments, Deep Tissue massage, electrical muscle stimulation, ultrasound, and stretching can be used in the treatment of spinal subluxations. Manipulation of extremity joints may also be utilized when necessary. Consent is given for myself and those under my care for which I am legally responsible. I give this consent to the Doctor of Chiropractic named above and/or other licensed Doctors of Chiropractic at Bullard Chiropractic Clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named above, and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I am informed and fully understand that in the practice of chiropractic, as in the practice of medicine, there are some risks to treatment. These risks include, but are not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and complications. I wish to rely upon the Doctor to exercise judgement during the course of the procedure, which the Doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I am also aware that utilization of the Pro-Adjuster and other non-force techniques greatly diminish the possibility of these injuries.

I have read, or have had read to me, the above consent, and I have also had an opportunity to ask questions about its content. I intend for 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.

By signing below, I agree to the above-named procedures.

Patient Name: _____ Date:_____

(Please Print)

Patient Signature: _____

Witness: _____ Date: _____