Fair Oaks Chiropractic: 4136 Pennsylvania Ave, Fair Oaks CA 95628
David W. Polley, D.C.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1. Some patients may experience some stiffness or soreness following the first few days of treatment.
2. Some types of manipulation have been associated with injuries to the arteries of neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3. Other risks to treatment may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.
4. The doctor will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which the doctor will check for during the history, examination, and x-ray (when warranted). I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I consent to the chiropractic treatments including spinal manipulation, various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, associated with, or serving as back-up for the doctor of chiropractic listed below, including those working at Fair Oaks Chiropractic or any other office or clinic. I have read, or have had read to me, the above consent. I intend this consent form to apply to all my present and future chiropractic care.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by doctor of staff:

_____
Witness to Patient's Signature:

_____
Date Signed

To be completed by patient's representative, if necessary, e.g., if patient is a minor or is physically or mentally incapacitated:

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

As:_____
Relationship of Authority of Patient's Representative

_____
Date Signed

To be completed by doctor and patient:
I acknowledge I have discussed the associated risks as well as the nature and purpose of treatment with my chiropractor.

_____
Patient (or Patient's Representative) Signature/Date

_____
David Polley, D.C./Date