

DISCLOSURE & CONSENT CHIROPRACTIC ADJUSTMENT AND CARE

TO THE PATIENT: *You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make a decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Stephanie Allen Mueller-Planitz, D.C., and/or other licensed Doctors of Chiropractic and Licensed Massage Therapists or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a back up for Doctor Allen. I have the opportunity to discuss with Doctor Allen, or any other Doctor of Chiropractic in the clinic, my diagnosis, the nature and procedure of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injury, strokes dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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 on the facts them known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment form my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

*To be completed by the patient's representative, if necessary:
Additionally, I consent to allow any care recommended to be performed on my child or child under my legal guardianship.*

Print name

Print name of patient

Signature of patient

Print name of patient's representative

Date Signed

Signature of patient's representative

As: _____
Relationship or authority of patient's representative

Date Signed

To be completed by doctor or staff: Witness to patient's signature: _____

Date: _____ Translated by: _____