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Informed Consent To Chiropractic Adjustments And Physical Therapy Care

Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multi-disciplinary studies conducted over many years, and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms.

Physical therapy is the evaluation or treatment of a person by the use of the effective properties of physical measures and heat, cold, light, water, electricity, sound, and air; and the use of therapeutic massage, therapeutic exercise, mobilization, and the rehabilitative procedures with or without assistive devices for the purposes of preventing, correcting, or alleviating a physical or mental disability, or promoting physical fitness and well-being.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our chiropractic method is a specific adjustment of the spine and other joints.

HEALTH: A state of optimal physical, mental and social well-being; not merely the absence of disease.

SUBLUXATION: A misalignment or restriction of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This results in a lessening of the body's innate ability to express its maximum health potential subluxations may also occur in other joints in the body.

OUR MAIN OBJECTIVE, and the goal of chiropractic, is to eliminate interference to the expression of the body's innate intelligence and its healing potential. Our method uses specific adjustments to correct subluxations.

Patient Rights

1. All persons who seek chiropractic/physical therapy care have the right to service regardless of age, gender, race, nationality, religion or politics.
2. Clients have the right to refuse chiropractic/physical therapy services.
3. Clients have the right to privacy, confidentiality, self-determination including participation in decisions about care, cease therapy, and access to second opinion.
4. Clients have the right to be protected from over-servicing.
5. Clients have the right to be referred to more suitably qualified persons.
6. Clients have the right to complain and to have the complaint managed sensitively.
7. Chiropractic/Physical therapists have the absolute responsibility to ensure that their behavior is at all times professional, ensuring that the potential for sexual misconduct cannot arise.
8. Expect that chiropractor/physical therapist shall provide consultation, evaluation, treatment, and preventative care in accordance with the laws and regulations of Illinois State.

Patient Responsibilities

1. Provide your clinician complete and accurate health and insurance information concerning illness, hospitalizations, allergies and function
2. Request additional information when you do not understand
3. Inform your clinician if you anticipate problems complying with the treatment plan
4. Provide your clinician with a copy of your advance directive (living will), if you have one and if appropriate
5. Follow provider rules and regulations, including timely notification of cancellation
6. Demonstrate respect and consideration for other patients and facility staff
7. Participate in the development of the plan of care
8. Notify your clinician of any changes in your condition

I hereby request and consent to the performance of physical therapy/chiropractic adjustments and other chiropractic procedures, and if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or anyone working in this office authorized by the doctor of chiropractic.

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

I further understand and am informed that, as in all health care, in the practice of chiropractic/physical therapy there are some very slight risks of treatment, including but not limited to, muscle strains -and sprains, disc injuries, and strokes. 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, is my best interest.

I have read the above consent. I have also had the opportunity to ask questions about its consent, and 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	**Signature of Patient or Guardian**
______________________________	______________________________
Date	**Witness**