Informed Consent

I, _____(print name), hereby request and consent to the performance of chiropractic procedures, including a comprehensive exam, diagnostic testing, physical therapy techniques, massage or manual therapy, adjustments or manipulation, and acupuncture on me which are recommended by the doctors at Fox Valley Health and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by or associated with Fox Valley Health.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Although these complications are rare, they include but are not limited to, muscle sprain/strains, dislocations, fractures, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Although our patients are screened for indications that they are candidates for chiropractic manipulation to the best of our ability, I do not expect the doctor to be able to anticipate all risks and complications during the course of the procedure(s). Therefore, the doctor based upon the facts then known, will act in the best interest of the patient. I understand that I can terminate treatment at any time, even during the course of any of the chiropractic procedures listed above.

Emergency Contact

In the event that we would need to communicate your healthcare information, to whom may we do so?

Name: _____ Number: _____

Relationship: _____

_____ _____

Signature of patient Doctor Signature

_____ _____

Signature of Patient's Parent/Legal Guardian Date

_____

Date