Crosby Chiropractic Center

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) and/or anyone working in this office authorized by the doctor(s).

I further understand that such chiropractic services may be performed by the doctor(s) at Crosby Chiropractic Center and /or other licensed Doctors of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Rob Rosenbaum and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I understand there is also a risk of increased pain during the healing phase of my care, as my body begins to restore to normal health. I understand that this may be normal and can indicate healing. The risks of not getting my prescribed treatment can include disc and spine degeneration, loss of mobility, loss of function, and loss of muscle tone.

I do not expect the doctor(s) to be able to anticipate and explain all risks and complications. Further I wish to rely on the doctor(s) to exercise judgment during the course of the procedures which the doctor(s) feel are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask question about its contents, and by signing below, I agree to the treatment recommended by the doctor(s). I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____

Print Patient's Name

_____

Signature of Patient

_____

_____/_____/_____ Date

To be completed by the patient's representative, if necessary. (ie. If the patient is a minor or is physically incapicated)

_____

Print Name of Representative

_____

Signature of Representative

_____

_____/_____/_____ Date

Doctor's Signature: _____ Date _____/_____/_____