Advanced Chiropractic Health Center
Working for your wellness, naturally

Charles W. Chapple, D.C., F.I.C.P.A.
Acupuncture, Applied Kineseology and Chiropractic Pediatric Certified

Informed Consent

Please read this entire document prior to signing. Ask questions before you sign if there is anything that is unclear.

Based on my complaints and the history I have provided, I hereby authorize Advanced Chiropractic Health Center and At Your Sercive Chiropractic House Calls, and its licensed doctors and assistants to undertake an examination and provide an evaluation and treatment plan that may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I understand that state law entitles me to receive information concerning my condition and proposed treatment and refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on the Advanced Chiropractic Health Center and At Your Sercive Chiropractic House Calls doctors and agents of to make those decisions about my care based on the facts they believe are in my best interest.

As a part of the analysis, examination, and treatment, I am consenting to services that may include: Chiropractic adjustment, palpation, massage/manual release therapy, kineso-taping, Acupunture techiques, spinal decompression, intersegmental traction, vital signs, range of motion testing, orthopedic testing, neurological testing, muscle strength and nutrient testing, postural analysis testing, Applied Kineseology techniques, physiotherapy, Laser/light and hot/cold therapy, EMS, nutrition/supplementation, rehab/therapeutic procedures and activities, radiographic studies and other testing and procedures as necessary. The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments, and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

Based on current findings, I understand that the Practice doctors will discuss my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment, and the reasonable alternatives to the proposed treatment. The office will provide the cost of my treatment per visit (or provide me with a current fee schedule/also on our web-site).

I have also been advised that although the incidence of complications associated with chiropractic and these services are very low, anyone undergoing adjusting or manipulative and these procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by thedoctor. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the Doctor's attention, I understand that it is my responsibility to inform the Doctor before treatment.

360 E. Irving Park Road • Roselle, Illinois 60172 • (630) 894-8778 • Fax (630) 894-8873

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The availability and nature of other treatment options may include self-administered, over-the-counter analgesics and rest, medical care and drugs such as anti-inflammatories, muscle relaxants, and painkillers, injectibles, hospitalization or surgery. If one chooses to use one of the above-noted "other treatment" options, one should be aware that there are risks and benefits of such options, possibly influencing treatment at this office, and I understand that I may wish to discuss these with my primary medical physician.

The risks and dangers to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility, setting up a pain reaction and further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

This document is intended as a general, broad-based consent that applies to any and all contemplated procedures. I have discussed all of the above risks and benefits with the Practice, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case, and therefore consent to treatment.

I understand and accept that:

1. I have the right to withdraw from or discontinue any treatment at any time which could effect the treatment goals and outcomes, and the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve making judgments based upon the facts known to the doctor during my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee results with respect to any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand the care and treatment I (or as guardian for) may receive to my satisfaction. My signature below acknowledges my consent to the Practice's, physicians and agents examination, evaluation, and proposed course of care and treatments.

_____ _____
Witness Patient's Printed Name

_____
Patient's (Guardian) Signature Date

_____
Signature of Doctor

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