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 TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments, any other Chiropractic procedures and associated procedures, including but not limited to examination, tests, diagnostic x-rays and tests, rehabilitation, physical therapy techniques, acupuncture, applied kinesiology, bioenergetics, nutrition and homeopathic on me (or on the patient for which I am legally responsible) which are recommended by the doctors of Chiropractic named below and or/ whomever he may designate as agents of Advanced Chiropractic Health Center.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment and associated treatment. There are some risks to treatment, including but not limited to sprains/strains, fractures, dislocations, worsening of concerns and interruptions in nerve and blood flow. I do not expect the doctors to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctors feel at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctors named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments, treatments and other recommended procedures (e.g. listed above) and have had my questions answered to my satisfaction. I understand that the results are not guaranteed and are not meant to replace standardized tests, diagnostic and treatment of medical conditions. I hereby give my consent to Chiropractic treatment (and above mentioned treatments), I intend this consent form to cover the entire course of treatment.

Name(s) of Doctor Treating This Patient

Dr. Charles W. Chapple, D.C..F.I.C.P.A / DBA Advanced Chiropractic Health Center

Any and All Treating Physicians and Staff

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____

Signature of Patient (Or Representative for minor or a guardian/ Print minors name): Date

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Witness to Patient's Signature: Date