CHICAGO NEUROSCIENCE INSTITUTE

Consent for Care/Treatment

1. I hereby authorize and voluntarily consent to care/treatment for my condition(s) at the Chicago Neuroscience Institute, Ltd. (hereinafter referred to as CNI), which may include the performance of diagnostic procedures, interpretation of diagnostic studies including imaging, the administration of medication, nutritional supplementation, chiropractic care, joint and soft tissue manipulation, physical therapy and procedures requiring the use of needles as deemed necessary by my physician(s), his or her assistants, consultants, or designees for the diagnosis or treatment of my disorder(s)/illness(es).

2. I understand and am informed that in the practice of medicine and chiropractic, as in other forms of health care delivery, there are some risks associated with some diagnostic tests and therapeutic procedures, including but not limited to bruises, pain, fractures, allergic reactions, disc injury, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and 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 as then known, is in my best interest.

3. Realizing that outpatient care/treatment requires the cooperation of physicians and support healthcare personal to include nurses, therapists and technicians, I hereby give consent for their communication and all procedures provided to me by qualified physicians and other personnel working under the supervision and direction of my attending physician at CNI.

4. I am aware that the practice of medicine and chiropractic is not an exact science and I hereby acknowledge that no guarantees have been made to me as to the result of examinations, treatments or recommendations.

5. I hereby authorize CNI to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience, any specimens or tissue taken from my body during my care at CNI.

6. I hereby understand that the responsible third party or I may be billed for the completion of submitted paperwork and for review of any outside medical records or imaging studies. This includes record reviews for the purpose of a second opinion and clinical correlation.

7. I understand that a specialized diagnostic or focused therapeutic approach to neurological or related orthopedic conditions at CNI is not to take the place of my general healthcare. I understand that I should consult with my personal/family medical physician/medical internist for general care and for the coordination of my healthcare with other specialists. It is the policy of CNI to recommend that each patient receive at a minimum semi-annual comprehensive examinations from their attending medical internist/medical family physician unless deemed otherwise. This approach helps facilitate timely diagnosis and intervention.

8. I understand that if I am seeking a diagnostic opinion at CNI I am responsible to follow up with the recommended physician(s) for review of therapeutic options and/or intervention. If I do not follow through with the recommended course of care including diagnostic follow-up, I understand that it could lead to an unwanted outcome including but not limited to chronic pain, physical disability, loss of limb, cognitive impairment or death.

9. I understand that CNI provides facilities, equipment and clerical support services for of physicians so they may render diagnostic and therapeutic services to their patients. I recognize with the exception of designated "staff CNI physicians", the physicians rendering services to me, including but not limited to, attending physicians, consultants, pathologists, radiologists and neurosurgeons are independent practitioners and are not employees or agents of CNI and may not be covered by CNI managed care plans. In some cases I can expect to receive a separate bill from the independent physicians providing services at CNI.

10. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the content, and by signing below I certify that I understand its contents. I intend this consent form to cover the entire course of evaluation and care for my present condition, complications related to my condition and for any future condition(s) for which I seek treatment.

Signature of Patient/Legal Guardian:_____ Date:_____

Printed Name:_____ Date:_____

Witness:_____ Date:_____