**Chiropractic Informed Consent to Treatment**

I hereby consent to the performance of Chiropractic Adjustments and treatment such as physiotherapy, diagnostic x-rays, and any related therapies by the Doctor of Chiropractic named below or a covering Chiropractor.

I have had the opportunity to discuss the purpose of Chiropractic adjustments and procedures with the Doctor. I understand that this doctor does not perform breast, pelvic, prostate, rectal or full skin evaluations; these examinations should be perfomed by your family physician, gynecologist /urologist, and dermatologist to exclude cancers or any abnormal skin lesions requiring further treatment.

**Risks:**

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of Chiropractic, there are some risks to treatment including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations, sprains, and death. I do not expect the Doctor to be able to anticipate and explain all the risks and complications, and I 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 then known, is in my best interest.

**Potential Benefits / Anticipated outcomes of treatment:**

I further understand that Chiropractic Adjustments and supportive treatment are designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach and may prevent the need for more invasive procedures. However, like all other healthcare treatments, results are not guaranteed and there is no promise to cure. The risk of degeneration may occur if spinal problems are not corrected.

**Alternatives:**

I further understand that there are treatment options available for my condition other than Chiropractic care. These treatment options include, but are not limited to, self-administered over the counter medications, medical care utilizing prescription medications, physical therapy, surgery, or choosing no treatment at all. At the Doctor's discretion, it may be necessary to be referred to another healthcare provider. I understand that I have a right to seek a second opinion.

**I have read and understand the above consent. I have also had the opportunity to ask questions. By signing below, I agree to Chiropractic care and the entire course of treatment for this and any future conditions.**

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**Name of Patient Signature (Parent if minor) Date**

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**Mary Ann Musa, R.D., D.C.**

**Kick Some Mass Orange Park, Florida**