INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic manipulation(s) and any other Chiropractic procedures, including examination tests, diagnostic x-rays, and physiotherapy techniques, on me (or on the patient named below for which I am legally responsible), which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, that there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strains, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to reply on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest!

I have had the opportunity to discuss with the doctor named below and/or with the office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the Chiropractic adjustment and related treatment. By signing the below, I state that I have weighed the risks involved, in undergoing treatment and have myself, decided that it is in my best interest, to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

CHIROPRACTIC SPORTS MEDICINE
24741 Alicia Parkway, Suite D
Laguna Hills, CA 92653
(949) 951 -1160

Print Name(s) of Doctor Treating this Patient

Steve J. Costales, DC, MS, ATC

_____

Patricia K. McHone, DC

_____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Guardian Date