Informed Consent

SCOPE OF TREATMENT: Your treatment will primarily involve chiropractic procedures performed by the Doctor of Chiropractic who is named below, or another licensed Doctor or support staff member of Health Webb LLC. Such chiropractic procedures may involve the manual or mechanical manipulation of your joints and body. The movement may cause an audible "popping" or "clicking" noise, similar to the sound made when you crack your knuckles. As part of your treatment, the Doctor or staff member may also conduct spinal manipulative therapy, adjustments, range of motion testing, muscle strength testing, massage therapy, postural analysis, ultrasounds, electrical stimulation, and xrays. You must inform the Doctor prior to treatment if you are pregnant, as x-rays may be hazardous to an unborn child.

There are other treatment options that may be available for your condition that do not involve chiropractic procedures. They include surgery, hospitalization, bracing, physical therapy, steroid injections, prescription drugs, muscle relaxers, and over-the counter painkillers, among others. Please note that these other treatment options also involve their own risks.
Initials:_____

RISKS: Chiropractic treatment does not guarantee certain results or promise to cure any ailments. Additionally, as with any health care treatment, chiropractic treatment involves certain complications or risks. These may include, but are not limited to, the following: stiffness or soreness; muscle strain or spasms; aggravation or an increase of symptoms; disc injuries; dislocations; fractures; and stroke. Please note that remaining untreated may also involve certain risks and may hinder the success of any future treatment.

It is very common for patients to experience slight stiffness after treatment. More serious complications, such as fractures, are rare and generally result from an underlying bone weakness. The incidences of stroke are also exceedingly rare and have been estimated to occur between one in one million and one in five million adjustments.

Your Doctor will make every reasonable effort to lessen any risks of treatment, but he or she may not be able to anticipate all complications. You are responsible for informing the Doctor if you have any condition or experience any symptoms that may not otherwise come to the Doctor's attention. Initials:_____

CONSENT: I have read, or have had read to me, this Informed Consent. I have discussed it with the Doctor who is named below and have had the opportunity to ask questions about it. By signing below, I acknowledge that I agree to receive treatment, understand the risks involved, and consent to that treatment. I intend for this Informed Consent to cover the entire course of my treatment with Health Webb LLC, including any future conditions for which I may seek treatment. I wish to rely on the Doctor to exercise his or her best judgement during the course of my treatment to accomplish what he or she feels to be in my best interests. Initials:_____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMED CONSENT

_____ _____
Signature of Patient or Parent / Guardian Date

_____ _____
Printed Name of Patient Printed Name of Parent / Guardian (if minor patient)

_____ _____
Signature of Doctor of Chiropractic Date

_____
Printed Name of Doctor of Chiropractic

REAFFIRMED CONSENT: Initital_____ Date_____

_____
Signature of Patient/Guardian/Parent

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