Informed Consent

It is NOT the goal of chiropractic to treat any symptom, disease, or condition. Rather we care for the spine for the sole purpose of removing interference with and tension from the Nervous System. We also employ muscle work to improve muscle and joint stability and function. Every person is better with improved neural and musculo-skeletal function and this alone justifies our care. Our goal is to get your child's body working properly so your child can heal themselves. Research studies report improved health and wellness that is consistent with the care given. However, just what specific benefits your child will receive, no one can predict.

There are certain risks that have been reported to be associated with chiropractic care. Such risks include, but are not limited to fractures, dislocation, bruising, stroke, Horner's syndrome and other neurological complications. However, these incidents are extremely rare and the doctor will use his best judgment to try to avoid any negative events. I understand that the most common adverse reactions to care is temporary soreness. By my signature I give my consent for the Doctor of Chiropractic to examine my child's spine and/or extremities and/or muscle function. If I choose for my child to receive care, my payment for such services, and my bringing my child to each visit, in addition to my signature here, will serve as acknowledgment of my permission for the Doctor of Chiropractic to deliver such care to my child.

Privacy Notice

Your child's health information is private and protected by law. Your child's health information will only be used or disclosed for the purposed of giving care, billing, or supporting day-to-day operations in this office. You have a right to review your child's office file. You may restrict all or part of your child's health information. Our privacy manual is available at any time for you to review, and a detailed explanation of the privacy policy is available upon request.

I have had a chance to ask questions about the privacy policy and I give my permission to this office to disclose my child's protected health information in accordance with such policies. I have read and understood the informed consent and give my permission for the Doctor of Chiropractic to deliver care to my child.

_____

Child's Name

_____

Parent Name Parent Signature Date

_____

Witness Signature Date

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