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**Advanced Chiropractic & Sports Care**

**Informed Consent/ Consent to Treat**

I have been informed of the nature, purpose, scope of care to be provided by the doctor of Advanced Chiropractic & Sports Care, the possible limitations and consequences of that care, and the possibility that the care given by Advanced Chiropractic and Sports Care may not completely resolve my complaint, dysfunction or condition. I consent to care and recommendation made by the doctors of Advance Chiropractic and Sports (or my children, if minors) including but not limited to examinations, x-rays, chiropractic adjustments, adjunctive therapies and rehabilitation. I understand that my care will be individualized and therefore may not be comparable with standards or guidelines required by insurance companies, Medicare, professional associations or consensus groups. I understand that my treatment will comply with the standard of care procedures, including those used in this clinic, have risks associated with them. Risks although rare, associated chiropractic procedures may include minor aggravation of symptoms, muskoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome, including cerebrovascular accident or death through complication factors. I hereby accept the risks associated with any care by the doctor or staff of Advanced Chiropractic and Sports Care and release Advanced Chiropractic and Sports Care of to my liability for any injury or loss directly related to care I have received at this clinic. In the event of an emergency I grant the doctors and staff of Advanced Chiropractic and Sports Care permission to provide emergency care and any follow up necessary including referral to emergency medical services or other medical facility. I am signing this consent and acceptance of terms after having fully informed to my satisfaction of the risks and benefits of proceeding with care. I have been informed and fully understand that there are not guarantees of treatment success and consent and elect to the care provided.

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Patient Signature Date

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Print Patient Name