INFORMED CONSENT TO CHIROPRACTIC CARE

IN OUR OFFICE WE USE AN EXTENSIVE AMOUNT OF DIAGNOSTIC PROCEDURES TO DOCUMENT AND VERIFY INJURIES/ILLNESSES. IN CONJUNCTION WITH OUR STANDARD AND CONVENTIONAL EVALUATION PROCEDURES, OCCASIONALLY WE MAY FIND IT NECESSARY TO UTILIZE AN EXPERIMENTAL DIAGNOSIS PROCEDURE (WHICH IS SAFE AND NON-INVASIVE). BY SIGNING BELOW YOU CONSENT TO THE PERFORMANCE OF THESE PROCEDURES, AS WE MAY CONSIDER THEM NECESSARY OR ADVISABLE IN THE COURSE OF YOUR CARE. IF YOU HAVE ANY QUESTIONS OR CONCERNS PLEASE FEEL FREE TO CONSULT WITH YOUR DOCTOR.

THE PROBABILITY OF SOME RISK OCCURING

FRACTURES ARE RARE OCCURRENCES AND GENERALLY RESULT FROM SOME UNDERLYING WEAKNESS OF THE BONE, WHICH WE CHECK FOR DURING THE TAKING OF YOUR HISTORY AS WELL AS DURING THE EXAMINATION AND X-RAY. THE OCCURRENCE OF STROKES HAS BEEN THE SUBJECT OF TREMENDOUS DISAGREEMENT WITHIN AS WELL AS OUTSIDE OF THE PROFESSION WITH ONE PROMINENT AUTHORITY SAYING THAT THERE IS AT MOST A ONE-IN-A-MILLION CHANCE OF SUCH AN OUTCOME. SINCE EVEN THAT RISK SHOULD BE AVOIDED IF POSSIBLE, WE EMPLOY TESTS IN OUR EXAMINATION WHICH ARE DESIGNED TO IDENTIFY IF YOU MAY BE SUSCEPTIBLE TO THAT KIND OF INJURY. OTHER COMPLICATIONS ARE ALSO GENERALLY DESCRIBED AS “RARE.”

I HAVE HAD THE OPPORTUNITY TO DISCUSS WITH THE DOCTOR NAMED BELOW THE NATURE, PURPOSE AND RISK 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 THE ABOVE EXPLANATION OF THE CHIROPRACTIC ADJUSTMENTS AND RELATED TREATMENTS. BY SIGNING BELOW I STATE THAT I HAVE WEIGHED THE RISK 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 RISK, 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.

NAME AND ADDRESS OF OFFICE
Arlington Holistic Health
4304 SW Green Oaks Suite 150
ARLINGTON, TEXAS 76017

NAME OF TREATING DOCTOR
JEFF A. CARNANHAN, B.S., D.C.

_____
PRINTED NAME OF PATIENT

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PATIENT’S REPRESENTATIVE DATE

_____ _____
WITNESS TO PATIENT’S SIGNATURE DATE