BILLERICA CHIROPRACTIC OFFICE, PC

CONSENT TO CHIROPRACTIC CARE

I, ____________________________, date of birth ___________ authorize the performance upon myself of the following procedure(s);

Examination and/or treatment

I realize that these procedures are to be performed by or under the direction of chiropractic physicians, employed by BILLERICA CHIROPRACTIC OFFICE, PC Physicians, Chiropractors, Osteopaths and Physiotherapists using manual manipulation are required to advise their patients that:

1. With neck problems there have been rare incidents of injury to the vertebral artery during the course of care. These have caused strokes or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are approximately 1 in 3-6 million adjustments. By comparison, it is estimated that 100,000 to 150,000 people die each year from adverse reactions to prescription drugs making prescription drugs the 4th leading cause of death in the U.S.
2. With neck or back problems there have been rare incidents of rib separation or fracture, bruising, swelling, or aggravation of symptoms.

APPROPRIATE TESTS WILL BE PERFORMED ON YOU TO MINIMIZE YOU RISKS

I hereby consent to the chiropractic care as indicated and explained to me. If during the course of care, unforeseen conditions are discovered or unusual conditions develop, I further consent to such additional diagnostic measures and care as may be indicated by sound and prudent chiropractic practice, which may require additional x-rays, chiropractic, orthopedic, neurological, and/or laboratory testing or consulting with another doctor.

No guarantee or warranty has been made to regarding my results.

I have read and understood the above statements and hereby give my consent to chiropractic care.

Date: ____________________ Signed: ________________________________

Witness: _______________________ Relationship: ____________________

EDUCATION USE ONLY