FREEPORT FAMILY CHIROPRACTIC CLINIC, LLC

40 Washington Street Freeport, FL 32439

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**INFORMED CONSENT FOR CHIROPRACTIC TREATMENT**

I hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Jennifer L. Laird, D.C./Freeport Family Chiropractic Clinic. This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

While Dr. Jennifer L. Laird believes this recommended therapy to be reasonable and medically necessary and the anticipated benefits far outweigh the risks, some patients wonder what complications might occur. Thus, Dr. Jennifer L. Laird believes you should be made aware of these risks before treatment.

For the vast majority of patients, there are few, if any risks; and most of the risks are minimal, such as soreness.

As with any health care procedures, there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. While none of these complications has ever occurred in our office, should they occur in your case, for your protection, you would be referred immediately to another physician for treatment or the closest ER.

I have the right to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I also understand that specific results are not guaranteed. This consent is designed to inform rather than frighten you. Thus, if you have any questions Dr. Jennifer L. Laird will be glad to discuss them with you before beginning treatment.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to this treatment. I intend for this consent to cover the entire course of my treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

Printed name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Representative (if minor or handicapped) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_