Informed Consent for Treatment

I hereby request and consent to the performance of naturopathic and chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, 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 procedures which the doctor feels at the time, based upon the facts then known, that are in my best interest.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of treatment. I state that I have been informed and weighed the risks involved in naturopathic and chiropractic treatment at this health care office. I have decided that it is in my best interest to receive treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition 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 Guardian/Parent Date
(If patient is under 18 years old, or is physically or mentally unable to sign
-this signature indicates guardian consent for the Doctor to treat the patient.)

______________________________ _______________
Witness to Patient's Signature Date

Joseph L. Dumovic, D.C., N.D., Inc., P.S.
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