INFORMED CONSENT

You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo such care after being advised of the known risks. This disclosure is not meant to frighten or alarm you. It is simply to make you better informed in order that you may give or withhold your consent.

NATURE AND PURPOSE OF CHIROPRACTIC

Adjustments are made by chiropractors to correct spinal subluxations. One of the most common disturbances to nervous system function is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by such subluxation(s). This is done with a chiropractic adjustment following a chiropractic examination, which may include, but is not limited to, spinal and physical examination, orthopedic and neurologic testing, palpation, specialized instrumentation, radiology examinations, and laboratory tests.

An adjustment is the application of a quick precise movement over a very short distance to the spine. There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand guided instruments..

Not only should you understand the benefits of chiropractic care and treatment in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological injury, fracture, vertebral artery syndrome (VAS) including stroke and perhaps, death through complicating factors.

AUTHORIZATION FOR CHIROPRACTIC CARE AND TREATMENT

I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. RALPH DAVIS TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATE THIS _____DAY OF _____ 20____, NEWNAN, GEORGIA.

_____

PATIENT'S SIGNATURE

_____

DOCTOR'S SIGNATURE

WHEN THE PATIENT IS A MINOR OR UNABLE TO CONSENT:

A. PATIENT IS A MINOR _____YEARS OF AGE

B. OTHER _____

PATIENT'S NAME:

PERSON AUTHORIZED TO SIGN FOR PATIENT, PLEASE PRINT NAME:

SIGNATURE OF AUTHORIZED PERSON: _____

RELATIONSHIP: ____ MOTHER, ____ FATHER, ____ LEGAL GUARDIAN