Central Chiropractic & Sports Medicine
611 N Central Ave. • Belmont • NC • 28012
Phone: 704-829-9200 • Fax: 704-829-5700

Authorization & Releases

Patient Name: ____

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physio-therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Central Chiropractic & Sports Medicine and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back-up for Central Chiropractic & Sports Medicine, including those working at the clinic or office listed or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office/clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the doctor(s) do not offer to diagnose or treat any condition or disease other than vertebral subluxation, nor do they offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic examination, abnormal or unusual findings outside the scope of chiropractic are discovered, the doctor will advise me and make the most appropriate referral.

I understand I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure(s) which the doctor feels, at the time, based upon the facts then known, is in my best interests. I understand that all adjustments are made in the open suite and that if I require private consultation with the doctor, I can arrange that with the front desk staff at any time during normal office hours.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above-named procedures, I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patient Signature ____________________________ Dependent's Name _________________________ Date __________________

Doctor Signature ____________________________ Date __________________

Authorization to Release Medical Records

I authorize the release of any medical information necessary to process my case and/or insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature ____________________________ Date ______________________

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the doctors and/or associates of Central Chiropractic & Sports Medicine have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: ____
Patient Signature: ____ Date: _______________________________________