Dr. Adam B. Cline/DC and Acupuncturist
Doctor of Chiropractic
Cline Chiropractic Corporation
1033 Sagamore Parkway W.
West Lafayette, IN 47906

INFORMED CONSENT TO CHIROPRACTIC AND/OR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic Adam B. Cline and/or other licensed doctors of chiropractic who now or in the future work at Cline Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic Adam B Cline and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

The doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, and therapeutic ultrasound may also be used.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to: fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

ACUPUNCTURE

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock or convulsions.

I have been advised that only sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him in my best interest.

Patient Signature_____ Date _____

Authorization for Release of Records, MRI Reports, and X-Rays

I herby authorize_____ to disclose to_____ or their agent any information which he/she may have acquired by examination or other means of my physical or mental condition; and I hereby release him/her of any consequence hereof.

_____ _____

Signature of Patient/Guardian Date