Informed Consent

I certify that the information I have provided to Motion Chiropractic is correct to the best of my knowledge. I will not hold my Doctor or any staff member of Motion Chiropractic responsible for any errors or omissions that I may have made in the completion of these forms. I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays, and physical therapies on me as deemed appropriate (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below.

Name of Doctor treating patient: Steven Hamvay, DC

I understand that as with any health care procedure, there are certain complications which may arise during a Chiropractic adjustment. It is necessary to inform the patient of such risks prior to initiating care. While Chiropractic Care is remarkably safe, you need to be informed about the potential risks related to your care before consenting to treatment. Specific risks and possibilities associated with Chiropractic Care:

Soreness – Chiropractic adjustments or any type of physical therapy procedures are sometimes accompanied with post treatment soreness. This is a normal and accepted response to chiropractic care and physical therapy. While it is not generally dangerous, please advise the doctor if you experience soreness or discomfort.
Soft Tissue Injury- Occasionally chiropractic adjustments may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury,
Rib Injury – Manual adjustments to the thoracic spine or mid back, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered a risk. Treatment is performed carefully to minimize such risk.
Stroke – Stroke is one of the most serious complications of chiropractic treatment. Some types of manipulations to the upper cervical area have been associated with injuries to the arteries of 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 on the doctor to exercise good judgment during the course of the procedure(s) which the doctor feels are in my best interest, based on the facts known.

Chiropractic care is a system of health care delivery and therefore we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. Our goal is to provide you with the very best care and if the results are not acceptable, we will refer you to another provider who we feel can assist you.
I understand that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment, I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

Health Record Consent:

Printed name of Patient: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

I hereby consent to any/all X-Rays taken on this visit. Initial: _____

If **female**, I hereby acknowledge that to the best of my knowledge, I am **NOT pregnant**. Initial: _____

Last menstrual cycle (Date) _____ Initial: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature _____