Palmer
CHIROPRACTIC
a family wellness clinic

7671 McLaughlin Rd. Falcon, CO 80831
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www.palmer-chiropractic.com

Informed Consent for Chiropractic Care

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. 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 Chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance in the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a specific application of forces called an **adjustment**. Our Chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with Chiropractic care may include, but are not limited to: muscle or ligamentous injuries, vascular injuries or fractures. Alternatives to Chiropractic care may include medications, surgery, and other alternative treatments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my satisfaction. The benefits, risks, and alternatives of Chiropractic care have been explained to me. By my signature below, I have read and fully understand the above statements and therefore accept Chiropractic care on this basis.

_____   _____ _____
Print Name   **Signature**   Date

OVER PLEASE….

IF PATIENT IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW:

Signature of Guardian _____

Relationship to Minor _____ **Date** _____

Consent to Use and Disclose Health Care Information for Treatment, Payment, or HealthCare Operations

I understand that as part of my healthcare, this practice originates and maintains my health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:
- A basis for planning my care and treatment
- A means for communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and other information to my bill
- A means by which a third party payor can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I hereby consent to the use and disclosure of my personal health information for the purposes listed above.

Patient Name - printed _____

Signature _____ **Date** _____

_____ _____
       Print name if different than patient name   **Relationship to Patient**

I authorize **Palmer Chiropractic PC** to speak to _____,

(relationship) _____, regarding any treatment/concerns regarding my healthcare.

Pregnancy Release -- This is to certify that to the best of my knowledge I am not pregnant and the doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____
             Signature   **Date of last menstrual cycle**