INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Dr Derakshani,

I hereby request and consent to the performance of Chiropractic treatments (also known as chiropractic adjustments, chiropractic manipulative treatments) and any other associated procedures; physical examination, test, diagnostic x-rays, physiotherapy, acupuncture, physical medicine, physical therapy procedures, etc, on me by the Doctor of Chiropractic named above and / or other assistants and / or licensed practitioners.

I understand as with any health care procedures, that there are certain complications, which may arise during treatments. Those complications include but are not limited to; fracture, disk injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in 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 upon the doctor to exercise judgment during the course of procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risk of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risk involved in chiropractic treatment at this office The Healing Joint. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

X______________________________

Printed name of patient

X______________________________

Signature of patient or legal guardian

Date:________/_________/_________