INFORMED CONSENT FOR CHIROPRATIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including physical examination tests, diagnostic x-ray(s), physical therapy techniques and massage on me (or the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for, associated with, or serving as back-up for the doctor of chiropractic named below:

Dr. John A Workman
Dr. Arthur H. Stewart, III

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. These complications may include, but are limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and/or separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contribution to serious 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 judgment during the course of the procedure(s) which the doctor feels at the time, based on the facts, then known, and are in my best interest.

I have had an opportunity to discuss with the doctor names above and/or with other qualified office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

Please check one: ( ) I have read, ( ) I have had read to me the above explanation of the chiropractic and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment recommended for my present condition and for any future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

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Printed Full Name of Patient

Signature of Patient	Date
Signature of Patient Representative (minor or incapacitated)	Date
Witness	Date
Translated By	Date

Reviewed 12/14/2005