

## **DISCLOSURE & CONSENT for CHIROPRACTIC ADJUSTMENTS AND CARE**

**TO THE PATIENT:** You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Michael Krauseneck, or by other licensed Doctors of Chiropractic serving as a backup for Dr. Michael Krauseneck.

I have had the opportunity to discuss with Dr. Michael Krauseneck, my diagnosis, the nature and purpose of chiropractic adjustments, and other procedures and alternatives.

Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. The success of chiropractic care often depends on environment, underlying causes and spinal conditions. It is important to understand what to expect from chiropractic health care services. The chiropractic adjustment and other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not perform chiropractic services if he is aware that such care may be contraindicated. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

---

To be completed by the patient:

\_\_\_\_\_

print name

\_\_\_\_\_

signature of patient

\_\_\_\_\_

date signed

To be completed by the patient's representative, if necessary e.g., if the patient is a minor or physically or legally incapacitated.

\_\_\_\_\_

print name of patient

\_\_\_\_\_

print name of patient's representative

\_\_\_\_\_

signature of patient's representative

as: \_\_\_\_\_  
relationship or authority of patient's representative

---

To be completed by doctor or staff

\_\_\_\_\_

witness to patient's signature

\_\_\_\_\_

date