FAMILY CHIROPRACTIC CENTER
Informed Consent to Chiropractic Care

Though the risks are small, as with other physician treatment methods, we feel that an informed consent is necessary to allow a patient to know the risks and to take those risks into consideration when deciding to have or not to have recommended chiropractic care. Chiropractic adjustments and therapeutic procedures (including spinal and/or extremity adjustments, heat/cold application, mechanical traction, adjunct physical therapy, and manual muscle therapy) are considered safe and effective methods of care. However, any procedure intended to help may have complications. 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. While the chance of experiencing complications is small, it is the ethical practice of Dr. Patrick T. Mayo, D.C. and the staff at Family Chiropractic Center to inform every patient about them. Risks include, but are not limited to, soreness, sprains, fractures, disc injury, strokes, dislocations, and increased symptoms or no improvement.

I have the opportunity to discuss with the doctor and/or staff members the purpose and benefit of chiropractic adjustments and other treatments. I understand that I have the right to ask questions about chiropractic care and to inform myself of the risks, and benefits of care before care begins and at any time during my treatment plan. Some of the alternatives to chiropractic include; over the counter medications, prescription medication, physical therapy, surgery, or to do nothing.

I hereby request and consent to the performance of chiropractic adjustments throughout my spine and/or other joints and extremities such as, but not limited to, feet, toes, ankles, knees, hips, shoulders, elbows, wrists, fingers, cranium, and to use other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or patient named below, for whom I am legally responsible) by Patrick T. Mayo, D.C. and/or other licensed Doctor of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for Dr. Patrick T. Mayo, D.C.

I also certify that no guarantee or assurance has been made as to the result that may be obtained. I have read this form and understand that I can ask questions at any time regarding this consent form.

I acknowledge that I have been informed and have had, and will have, the opportunity to discuss with my chiropractor and staff members the nature and purpose of chiropractic treatment in general and my treatment in particular (including chiropractic adjustments) as well as the contents of this consent form. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including chiropractic adjustments and physical therapy modalities. I intend this consent to apply to all my present and future care.

Signature of Patient/Guardian _____ Date _____

Staff Signature _____ Date _____

Medicare Patients Only:

- ❑ **I understand that the Family Chiropractic Center does not accept Medicare assignment.**
- ❑ The office will file all Medicare claims on my behalf.
- ❑ Medicare will only pay a portion of the adjustment fee. If there is a supplemental insurance it may pay an additional share. All remaining unpaid charges are the responsibility of the patient.
- ❑ Medicare will not pay for any **EXAMINATION, THERAPY, X-RAYS, or SUPPLEMENTS.** My secondary insurance will **NOT** pay for these either. These are my responsibility.
- ❑ Medicare will send any and all payments directly to me. I can either, wait for the Medicare payment and sign the check over to the office, or I can pay at the time of service.
- ❑ I am responsible for any and all charges for services, supplements, etc.

The Medicare office policy has been explained to me and I understand the policy.

Patient Signature _____ Date _____

Medicaid Patients Only:

The following services are **NOT** paid for by Medicaid:
❑ Examinations ❑ Physical Therapy Modalities ❑ X-Rays ❑ Blood/Urine Tests ❑ Nutritional Supplements
I acknowledge that I am solely responsible for paying for these services should they be rendered in my behalf.

Patient Signature _____ Date _____