Niequist Chiropractic

"Empowering People To Live Healthy Lives"

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is called "Informed Consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, and the potential effects on your health if you choose not to receive the care.

It is important that you understand, as with all healthcare approaches, results are not guaranteed, and there is no promise for cure. Also, there are some risks to care, including, but not limited to: aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, missed fractures, disc injury and strokes. With respect to strokes it should be born in mind that strokes occur in 3-4 of every 100,000 people whether they are receiving health care or not. As chiropractic can involve manual and/or mechanical adjusting of the cervical spine, it has been reported that chiropractic care may be a risk, as visiting any doctor may be a risk by association, for developing this kind of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important to understand that choosing not to receive care , if spinal issues like subluxations are present, could result in chronic ongoing pain and or disability.

I have read the above consent. I have had the opportunity to ask any questions about its content. By signing below, I agree to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover my entire course of care from all providers in this office for my present and future condition(s) for which I seek chiropractic care from this office.

Signature _____ **Date** _____

Complete if the patient is a minor.

Print child's name: _____

I, _____ being the parent or legal guardian of the aforementioned child have read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature _____ **Date** _____

Witness initials _____