

Informed Consent To Chiropractic Care

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Patient:

Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic 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 the doctor and support staff of Joseph F. Rogge, D.C..

I understand that chiropractic treatment is a procedure that involves movement of the joints and soft tissue and that physical therapy and exercise may also be prescribed.

I have had the opportunity to discuss with the doctor and/or other clinical personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to chiropractic care, which include rest, exercise, over-the-counter medications, medical treatment (drug therapy), as well as non-treatment, have been reviewed. The disadvantages to these approaches have been explained to me.

Although chiropractic adjustments are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I understand and am informed that as with any healthcare procedure, there are some risks to treatment. Risks include, but are not limited to, additional soreness, dizziness, fractures, nerve tissue damage, disc injuries, strokes, dislocations, sprains/strains, and skin irritation/burn. The probability of serious complications is slight and has been estimated at less than one in a million.

I understand that my treatment will consist of:

Chiropractic Adjustments

The risks associated with remaining untreated have been explained to me. These may include, but are not limited to, decreased mobility, increased pain/symptoms, scar tissue/adhesion formation, possible nerve damage, increased inflammation, and degenerative changes. It is probable that delaying treatment will complicate future care.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient's Printed Name _____

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____ Date _____

Doctor's Signature _____ Date _____