11010 South Tryon St. Suite 112
Charlotte NC 28273
(704) 504-1770

Informed Consent for Chiropractic Care

(Initials)

___________ I, give Proactive Chiropractic and Rehab Center permission and authority to care for me in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever his is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

____________ I, further understand that if I am accepted as a patient by Proactive Chiropractic and Rehab Center, I am authorizing them to proceed with any treatment that may be necessary. Accordingly, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

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Patient Name (Print) Date

____

Patient Signature