Patient Name: _____ **Date:** _____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and other procedures that may include nutritional testing, acupuncture, acupressure, trigger point therapy and electrical therapies.

I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time that is not reasonable to expect the doctor to anticipate or explain all risks and complications that an undesirable result does not necessarily indicate an error in judgment that no guarantee as to results has been made to nor relied upon by me, an I wish to rely on the doctor to exercise judgment during the course of the procedure which she feels at the time based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complication associated with chiropractic services is very low, anyone undergoing manipulative procedures, physical therapy, rehabilitation and acupuncture should know the possible hazards and complications which may be encountered or result. These include, but are not limited to: fractures, disc injuries, strokes, dislocations, sprains and those which relate to physical aberrations unknown or reasonably undetectable by the doctor. Acupuncture treatment may cause some localized soreness, bruising and/or brief bleeding.

A patient coming to the doctor gives the doctor permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed 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 provide specific healthcare, if he is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known or to learn through health care procedures, from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I understand it is my responsibility to fill out my case history completely and to the best of my knowledge; and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize Dr. Cheri to treat me.

I have read and understand the above consent. I have also had an opportunity to ask questions about its content, and by signing below, agree to the named procedures.

- I authorize payment to this office when using a check, debit or credit card.
- An additional charge of $30 will be charged for any non-payable check(s); bad check amount and fee are due before next office visit.
- A $30 fee will apply for any missed scheduled appointments, late changes, late cancellation or No Show.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I give this office the right to use my name for any in-office publications, to text or email me.

I acknowledge having the right to review and obtain a copy of the Notice of Privacy Practices of this office.

Patient's Signature: _____ **Date:** _____

Please inform us if the patient is under 18; a parent or guardian must sign consent to treat for the minor.

Guardian's Signature: _____ **Date:** _____

Dr. Cheri Ellis-Jablonowski, B.S., D.C.

Simply Chiropractic
& Acupuncture