INFORMED CONSENT

I hereby request and consent to the performance of chiropractic examinations, adjustments, and any other associated procedures. This consent is extended to other licensed chiropractic physicians or licensed massage therapists, who now or in the future, are employed by, working with, or associated with Eastpointe Integrated Healthcare. I understand that the doctor will use his/her hands or a mechanical device to move joint and that a “click” or “pop”, may be felt.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. This is estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgement during the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procedures, such as over-the-counter medications, medical care, hospitalization, and surgery. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this office. I have decided that it is in my best interest to receive chiropractic treatment and give my consent to treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

PHOTO CONSENT

If the moment arises, we would love to share your photo, story, or progress on our Social Media page(s) or website in the interest of showing others that “real people” visit our office and are smiling while they are here – and most importantly, getting fantastic results. Please check the box that applies to you:

- ○ Yes, you may use my picture on your website and social media.
- ○ No thanks! I’ll pass for now.

X-RAY RELEASE AND CONSENT

It is not unusual for our office to take digital x-rays in the process of determining how we can best help you. Please select from the following:

- ○ Yes, do whatever you feel is necessary to come up with the best care plan for me (and, NO, I am certainly NOT pregnant).
- ○ No thanks! I’ll pass for now, as I am pregnant or have another medical condition which contradicts me being exposed to x-ray.

I attest that the information on this form, and those preceding, is true and accurate to the best of my knowledge.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

____

Printed Name of Patient Date

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Signature of Patient Date

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Signature of Representative (if patient is a minor or has disability) Date