

# PAPPAS CHIROPRACTIC INFORMED CONSENT FORM

I HEREBY REQUEST AND CONSENT TO THE PERFORMANCE OF CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC PROCEDURES ON ME OR ON \_\_\_\_\_ BY ANTHONY N. PAPPAS, D.C.

I WILL HAVE AN OPPORTUNITY TO DISCUSS WITH THE DOCTOR THE NATURE AND PURPOSE OF CHIROPRACTIC ADJUSTMENTS AND OTHER PROCEDURES. I UNDERSTAND THAT THE PRACTICE OF NEITHER CHIROPRACTIC NOR MEDICINE IS AN EXACT SCIENCE, AND THAT MY CARE MAY INVOLVE MAKING OF JUDGMENTS BASED UPON THE FACTS KNOWN TO THE DOCTOR TO BE ABLE 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, AND I WISH TO RELY ON THE DOCTOR TO EXERCISE JUDGMENT DURING THE COURSE OF THE PROCEDURE WHICH THE DOCTOR FEELS AT THE TIME, BASED UPON THE FACTS THEN KNOWN, AS IN MY BEST INTERESTS.

I FURTHER UNDERSTAND THAT THERE ARE CERTAIN DEGREES OF RISKS ASSOCIATED WITH CHIROPRACTIC HEALTHCARE INCLUDING, BUT NOT LIMITED TO; FRACTURES, DISK INJURIES, STROKES, DISLOCATIONS AND STRAINS/SPRAINS. THEREFORE, WILLING TO ACCEPT AND CONSENT TO THE RISK ASSOCIATED WITH THE CARE THAT I AM ABOUT TO RECEIVE.

I HAVE READ OR WILL HAVE EXPLAINED TO ME THE ABOVE CONSENT. I WILL ALSO HAVE AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS' CONTENT. BY SIGNING BELOW I AGREE AND INTEND THIS CONSENT FORM TO COVER THE PROCEDURE(S) PRESCRIBED FOR MY CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

\_\_\_\_\_  
PATIENT'S NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT'S (OR PARENT'S) SIGNATURE