



INFORMED CONSENT TO CHIROPRACTIC/MASSAGE TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or *chiropractic manipulative treatments*) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio-therapy, physical medicine, physical therapy procedures, massage therapy etc. on me by the doctor of chiropractic named below and/or other assistants and/or licensed practitioners within Adventure Chiropractic.

I understand, as with any health care procedures, that there are certain complications which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complication, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named below and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic or massage treatment at this health care office. I have decided that it is in my best interest to receive chiropractic or massage treatment. I hereby give my consent to that 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.

SIGN ONLY AFTER YOU UNDERSTANT AND AGREE TO THE ABOVE

Printed name of Patient

X _____

Signature of Patient

____/____/____

Date

X _____

Signature of Representative (if patient is minor or handicapped)

____/____/____

Date

Dr. Ross C. Keys, CCSP

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