

# KATZ CHIROPRACTIC AND REHABILITATION CLINIC

954 North Street, Second Floor, Boulder, CO 80304

Office: (303) 938-9070 ~ Fax: (303) 938-9170

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## INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination tests, diagnostic x-rays, and physical therapy techniques on me (or on the patient named below for who I am legally responsible) by the doctor of chiropractic named below and/o other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working or associated with, or serving as a back-up doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I understand that, as with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, and muscle sprains and strains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interests.

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

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

### DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

\_\_\_\_\_  
Print Patient's name

\_\_\_\_\_  
Print name of Patient's Representative

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Relationship/authority of Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Translated or Read by Signature

\_\_\_\_\_  
Witness to patient's signature