INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

Name and address of office:
R.J. Ammon Chiropractic
4200 East Ave. Suite #102
Livermore, CA 94550

Doctor treating this patient:
Dr. R.J. Ammon, D.C.

Patient's Name: _____

You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I hereby request and consent to the performance of procedures which are within the scope of practice of chiropractic including, but not limited, to chiropractic adjustments, various modes of physical therapy and diagnostic x-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those working at the office listed above or any other office, whether signatories to this form or not.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop", and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment he/she determines is most appropriate for your condition.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. I understand an undesirable result does not necessarily indicate an error in judgment. I understand that results are not guaranteed, and there are risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment.

I understand and I am informed that there are some risks to chiropractic treatment, including but limited to; fractures, disc injuries, dislocations, sprains/strains, burns or frostbite (physical therapy), worsening/aggravation of spinal conditions, increased symptoms and pain, no improvement of symptoms or pain, and bruising.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

Permission for Physical Contact: I understand that, in the course of various chiropractic examination procedures and treatment methods, the doctor of chiropractic or other clinical staff may have to examine and physically contact portions of my body. I understand that any contact of an intimate or sexual nature is illegal, unethical, never a part of chiropractic professional examination or treatment, and is prohibited. Nevertheless, I also realized that some chiropractic procedures may require that the doctor or clinician contact me in some physically sensitive areas. I understand, however, that before any sensitive contact or procedure occurs the doctor or other clinical staff will explain to me; what is to be done, how it will be performed, why it will be performed, that I may refuse that particular test or procedure, or alternatively that I may request that another member of the staff be present for my safety and protection, and finally, that I will be given the oppurtunity to signal the doctor or clinician when I am ready to continue the test or procedure. I also agree that if I ever have any questions, doubts, or misgivings about the appropriateness of such contact I can discuss my concerns with the doctor, or other office or clinicial staff member. Finally, it is my understanding that I may revoke this permission at any time by a mutual exchange of written acknowledgments indicating that permission for any further physical contact by the doctor or other staff member with my person is prohibited.
I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused my pain in the past.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date