INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below which I am legally responsible) which are recommended by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the Doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, 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 serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended 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 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 conditions for which I seek treatment.

CONSENT TO TREATMENT OF A MINOR CHILD

I, being the parent or legal guardian, hereby authorize Dr. Blackman-Morgan and/or Dr. Silberhorn, and whomever they may designate as assistants to administer treatment as deemed necessary to my child.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient	
Signature of Patient	Date
Name of Patient's Representative (i.e. Parent/Guardian)	
Signature of Patient's Representative (i.e. Parent/Guardian)	Date
Relationship to Patient	

Blackman Family Chiropractic
5724 B Elevator Road
Roscoe, IL 61073
815-623-5460

Name(s) of Doctor(s) Treating This Patient:

Dr. Trina Blackman-Morgan

Dr. Brooke Silberhorn