Consent to Examine and Treat

Dr. Curtis Damien Chiropractic Physician

The undersigned consents to any examination (x-ray or otherwise) including, but not limited to, physical, orthopedic and neurological evaluation, visual inspection and palpation.

The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, joint mobilization, myofascial release, trigger-point therapy, ultrasound, electrical muscle stimulation, rehabilitative exercise, and infrared therapy.
Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint.

Because of modern techniques and equipment, examination and therapeutic procedures carry with them a low risk of complication. Even though problems seldom arise during these procedures, risks must be recognized and considered. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures and each case must be evaluated separately.

If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnostic procedures used in this clinic and have decided that it is in my best interest to submit to these procedures.

Printed name: _____ D.O.B:_____

Signature:_____ Date:_____

Financial Agreements /Late Payments

If an insurance company obligated to pay me or Community Chiropractic the charges for services rendered refuses to pay upon demand by the clinic, or if there is no insurance company, then I will pay for services rendered by Community Chiropractic. I will pay my account in full immediately, or I will keep my account current. If I have a liability/ personal injury claim and my attorney refuses to protect the interests of Community Chiropractic, or if I have not engaged the services of an attorney, I hereby promise to pay my bill in full within ten (10) days from the date my liability claim is settled or after the passage of two months from the date of my last treatment, whichever comes first. By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, reasonable attorney fees, court costs, and all other costs related to the collection of this debt.

Signature: _____ Date: _____

Patient SS# _____ Staff initials: _____