Alinea Chiropractic
Smyrna, GA

Treatment Consent Form

I understand that healthcare is not an exact science, and results are not guaranteed. When undergoing treatment, there are certain risks and increased potential for infection, in addition to a potential for unsuccessful results from the treatment. It is not reasonable to expect the doctor to anticipate or explain all risks and complications: that an undesirable result does not necessarily indicate an error of judgment. I knowingly and willingly consent to receive chiropractic treatment in person. _____ (Initial)

I hereby consent to the chiropractic treatment and procedures, including tests to manage my condition(s). I acknowledge that Dr. Taelyong and Dr. Sasha are not medical doctors. I understand that they provide nutritional and other health-related information to help me attain and maintain my best health.

I understand that in such chiropractic treatment, the doctor(s) will use a natural and conservative approach to my health needs; chiropractic care utilizes chiropractic manipulation, adjustments, exercise, nutrition, NeuroEmotional Technique, and various modes of physiotherapy. I wish to rely on the doctor to exercise judgment during the course of the procedure, which they feel at the time, based upon the facts then known, is in my best interest.

I understand that in a chiropractic manipulation or adjustment, I may feel and/or hear some popping of my joint(s), and cold/hot packs may be used. I understand that I am responsible for monitoring my condition throughout the treatment and will inform the office of any unusual symptoms that may occur.

I have been informed that in chiropractic treatment or management of conditions, such are the known risks:

- **Soreness, symptoms, or increased pain** may occur temporarily after the first few treatments.

- **Nausea or dizziness**. In the event that these symptoms are felt, I shall inform my chiropractor right away.
- **Fractures**. It is my duty to notify my chiropractor in case I am aware that I have weak bones or have been diagnosed with any bone-weakening diseases such as osteoporosis. The chiropractor may also halt the procedure if he or she finds that such or similar conditions are detected by him or her while under the latter's care.
- **Spinal disc conditions like bulges or herniation.** In such cases, I will have to notify my chiropractor when symptoms arise.
- **Stroke**. I am informed that there has been no known direct association between chiropractic treatment and stroke. However, for safety purposes, I shall inform my chiropractor of any symptoms of neck pains and headache, which are known symptoms of a stroke.

Confirmation

I have read the information above about chiropractic treatment, and my doctor/chiropractor discussed and explained it to me. I was given the opportunity to ask questions, all of which were answered to my satisfaction.

I have evaluated all the risks and benefits of the treatment and decided to undergo the recommended treatment. I hereby give my full consent to the treatment.

Dated this _____ day of _____,(Month) 20 _____ (Year)

_____ Name: _____

Patient signature (please print the name of the patient)

_____ Name: _____

Signature of guardian (please print the name of the guardian)

Office/Witness Signature _____