Informed Consent
McPeak Chiropractic LLC

I_____do hereby give my consent to the performance of conservative treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/ mobilizations involving movement of the joints and soft tissues. Physical therapy/ modalities,stretching, exercises and diagnostic testing including but not limited to: X-rays, EMGs, NGVs, Spirometry and blood draws may also be used. Although spinal manipulation/mobilization are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is possible to experience muscle soreness,/ bruising following treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.

Fractures/Joint Injury: | further understand that in isolated instances, if underlying physical defects, deformities and pathologies, like weak bones from osteoporosis, degenerative disc or other abnormalities are detected, this office will proceed with extra caution.

Physical Therapy: Some of the therapies used generate heat and may rarely cause skin irritation or bums. Despite precautions, if this occurs, there may be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Stroke: Although strokes happen with some frequency in our world, stroke from manipulations/ mobilizations are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments.

Falls: I understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks,, including falls and other similar injuries, and that the only alternative to entirely avoiding these risks would be to forgo rehabilitation altogether. I, therefore, acknowledge that falls and other similar injuries are an inherent riek of the rehabilitation process and accept that risk. Tests and other procedures have been performed on me to minimize the risk of any complication from treatment and | freely assume these risks.

Treatment Results: I also understand that there are beneficial effects associated with these treatments procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic and physical therapy, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctors choosing.

Alternative Treatments Available: Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription, or over-the-counter medications, exercises and possible surgery.

Supplements: $supplements can be used to reduce pain or inflammation. I am also aware that supplements may be recommended to me for the use of health-related conditions. These supplements may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse the pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy including exercise programs and/or stretching. Prolonged bed-rest contributes to weakened muscles, bones and joint stiffness. Exercises are of limited value, but are corrective of injured nerve and soft tissues.

Non-treatment: I understand the potential risks of refusing, discontinuing and/or neglecting care against the doctors advice, may include: increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy. I release McPeak Chiropractic LLC, from any responsibility for valuables, money and other personal possessions lost or stolen while on the premises. I consent to administration upon me of such routine care, supplements, and treatments including diagnostic procedures, as may be considered necessary or advisable. I understand that I am free to obtain information concerning any such care by asking clinic personnel. I have read or have had read to me the above explanation of McPeak Chiropractic LLC, Consent To Treatment. Any questions I have regarding these procedures have been answered to my satisfaction PRIOR TO MY

SIGNING THIS CONSENT FORM. I have made my decision, with careful thought, voluntarily and freely. I understand that I can withdraw my consent at any time in writing. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient:_____Date:_____

Signature of Witness:_____Date:_____