INFORMED CONSENT TO
CHIROPRACTIC TREATMENT

As with any healthcare procedure there are certain complications, which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

- Some patients may experience some stiffness or soreness following the first few days of treatment.
- Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
- I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
- Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separation, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue, which I checked during the history, examination, and radiographs (if warranted and/or available).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal and extremity manipulation. I intend this consent to apply to all my present and future chiropractic care.

Name of Doctor Treating This Patient: Christoph Muehlinghaus, DC

Acknowledgement of review of Notice of Privacy Practices: I, _____(patient name), acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Chiropractic Wellness Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my health information.

Cancellation Policy: We require a 24-hour cancellation notice. If less than 24 hours is given we will have to charge you a fee of $40 per 20-minute session.

Records copy fee: There will be a nominal $20 charge for copying patient's records for themselves, physicians, attorney's or insurance companies. Records will be ready within a reasonable time frame, upon receipt of the request.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____

Printed Name of Patient / Representative

_____ _____

Signature of Patient / Representative Date

2930 McClure Street, Suite 4, Oakland, CA 94609
Phone: (510) 326-0684 Fax: (510) 228-1660