

Informed Consent & X-ray Permission Form

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Jenny L. Crosby and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Dr. Jenny Crosby and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. Serious complications after manipulation of the cervical spine are estimated to be 1 in 4 million manipulations or fewer.¹ In comparison, there is a 3-4% rate of complications for cervical spinal surgery, and 4,000-10,000 deaths per million neck surgeries.² In fact, Ibuprofen (Advil, and Motrin) send 200,000 Americans to the hospital each year and account for an estimated 16,000 deaths. Acetaminophen (Tylenol) sends 56,000 people to the emergency room and accounts for 100 deaths a year.³

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I understand and agree that I am responsible for full payment for the chiropractic services provided by Crosby Chiropractic to the extent that such sums are not paid by the insurance company and/or the attorney. I understand that these fees are not negotiable since they are not payable at the time of service, but held as a courtesy.

I further understand and agree that if I file a claim against my personal health insurance plan for the physicians medical services for injuries arising out of an automobile accident, and my insurance plan discounts the physicians regular fee and will only pay the discounted fee, I will allow the physician to bill me for the difference between the physicians regular fee and the discounted fee, or the fee allowed by the insurance carrier. This sum, will be remitted from the monies recovered by settlement, judgment or verdict.

I authorize the performance of x-rays of myself and that to the best of my knowledge that I am not pregnant. I have been advised that x-rays can be hazardous to an unborn child.

I authorize the performance of x-rays of my minor child _____.

I authorize Crosby Chiropractic Centre to release to the following people any access to my health and financial records: _____.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

1)Lauretti W "What are the risk of chiropractic neck treatments?" retrieved online 08 028 2006 from www.chiro.org

2)*The cervical spine research society editorial committee*. The Cervical Spine, Second edition. Philadelphia: J.B. Lippincott Company 1990: 834.

3)USA Today citing the FDA in an article dated 12/19/06