



3572 Brodhead Road
 Suite 302
 Monaca, PA 15061
 (P): (878) 439-7157
 Todd Large, DC.

Informed Consent for Chiropractic Treatment

To the Patient: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of adjunctive procedures and diagnostic X-rays if deemed necessary. The chiropractic treatment may be performed by the Doctors of Chiropractic named above and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the Doctor of Chiropractic named above my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that there are some risks to chiropractic treatment including, but not limited to:

Broken Bones	Dislocations	Sprains/Strains
Burns of Frostbite (Adjunctive Procedures)	Worsening/Aggravation of Spine Conditions	Irritation of Disc Condition
Costovertebral Strains and Separations	No Improvement of Symptoms or Pain	Increased Symptoms and Pain

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition and any future reoccurrence of a similar nature.

To Be Completed by the Patient

To Be Completed by the Patient's Representative

Printed Name:

Print Name of Patient:

Signature of Patient

Print Name of Patient's Representative

Date Signed

Signature of Patient's Representative As:

Witness to Patient's Signature

Relationship/Authority of Patient's Representative