

Camp Chiropractic Center Informed Consent To Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy / physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic indicated below and/or other licensed Doctors of Chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as backup for the Doctor of Chiropractic named below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, I understand and am informed that, as is with all healthcare treatments, results are not guaranteed, and there is no promise to cure. In addition, I understand and am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short period of time, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns from heat lamps, ice or heating devices, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self administered, over-the-counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants and pain killers; physical therapy; acupuncture, massage, steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options. I have also been informed that an active order pertaining to Dr. David A. Camp and promulgated by the Department of Health is available for viewing online at www.doh.wa.gov. A copy of agreed order is available upon request.

I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the above named chiropractic and related procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from this clinic or Chiropractic doctor.

Patient or Representative or Guardian For Patient

Date