Informed consent to receive Chiropractic treatment &
Acknowledgement of Receipt on Notice of Privacy Practices

Print Form

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Please print this form and bring it with you to the office on your first visit.

Patient: Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, 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 back-up for the doctor of chiropractic named below.

I have had the opportunity to discuss with the doctor and/or with the other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I 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 periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 interests.
I further understand that Chiropractic adjustments and supportive treatment is 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, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.
I understand that I could be receiving the following treatment: Chiropractic care, massage therapy and / or physical therapy.

I have read, 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name _____ Date _____

Signature of patient _____ Date _____

Acknowledgement of Receipt on Notice of Privacy Practices

I hereby acknowledge that I have either:

☐ Check Box Declined to receive Valley Chiropractic's Notice of Privacy Practices or

☐ Check Box Received a copy of Valley Chiropractic's Notice of Privacy Practices by printing them myself from Dr. Leaps website. http://drleap.com/clients/16464/documents/HIPPA.pdf or have been given a copy from the front office.

Patient Name _____ Date _____

Signature of patient _____ Date _____