Allison Gardner, DC
3218 College Street Newberry, SC 29108
Phone: (803) 276-0019

INFORMED CONSENT FOR CHIROPRACTIC CARE

Patient Name: ________________________________

I hereby request and consent to appropriate chiropractic case management for me (or for the person named below, for whom I am legally responsible) at Midlands Chiropractic. Dr. Gardner has explained the following points of information to me:

- The purpose of chiropractic care is to optimize health by facilitating neurological and biomechanical integrity, which allows maximum expression of the body's innate recuperative abilities.
- Chiropractic adjustments are exceedingly safe when performed correctly. However, I understand there are some risks to care including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain every risk and complication. I will rely on the doctor's best judgement to protect my best interests. No guarantees of cure have been implied or given.
- A small force is introduced into the spine during a chiropractic adjustment that may lead to temporary discomfort. This is normal and is usually minor.
- The doctor will discuss any further risks inherent for my particular case during a report of findings, and will document this discussion in my case record. Any questions or concerns that I may have will be addressed at this time. I understand that I am an active participant in my chiropractic care and that I am encouraged to bring up questions or express my concerns.
- I give my doctor permission to communicate by telephone or email regarding matters of chiropractic care, appointment reminders or scheduling.
- Midlands Chiropractic is compliant with all HIPAA regulations, and takes all reasonable precautions to safeguard your privacy in all matters. The office is committed to upholding the security and confidentiality of personal information that you provide to us. By signing below, you authorize that your records of evaluation and treatment at Midlands Chiropractic may be forwarded to referring physicians, specialists, and billing/insurance companies who are involved in your healthcare.
- I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that Midlands Chiropractic will prepare any necessary reports and forms to assist in making collection from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for any payment, including that not covered by insurance company. I also understand that if I terminate my care, any fees for professional services rendered me will be immediately due and payable. (over)

The patient agrees that he/she is responsible for all bills incurred at this office.

- By signing below, I affirm that I have read, or had read to me, this consent document, and I agree to its provisions. I intend this document to cover the entire course of care now and in the future.
- I am free to refuse care or withdraw my consent and discontinue care at any time.

____ ___/___/___
Patient/Guardian's Signature Date

____ ___/___/___
Doctor Date