# Terms of Acceptance

Chiropractic care is a safe and effective approach for many health conditions, however as with any health care procedures, chiropractic treatment present the risks of complications or negative side effects. The list below includes the various treatments available in our clinics and the potential risks associated with them.

CHIROPRACTIC MANIPULATION
The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and your doctor has done a careful screening for the contraindications during the consultation and examination. Another more common side effect associated with chiropractic manipulation therapy is some soreness or stiffness following the treatment. The use of ice packs is recommended to reduce the discomfort.

COLD THERAPY
We place a towel around the pack to minimize the contact with the skin which can cause a local burn. If you have very sensitive skin, you can experience a reaction.

ELECTROTHERAPY
A small defect in the electrode coating, not always detectable by observation, may concentrate the current, causing a small burn to the skin. If you feel a sting where the electrode is place, please inform us. Electric stimulation causes muscles to contract and in rare instances a muscle cramp may occur during such treatment. Inform us if the procedure is uncomfortable.

COLD LASER THERAPY
Generally there are no side effects for cold laser therapy. The potential risk associated with this therapy is damage to the eye when the beam is pointed directly into the eye.

Any request for records must be done in writing and the records will be available in 2 business days.

I understand I will be responsible for payment of services and all fees are due BEFORE services are rendered. I also understand that I will be charged a collection fee if I do not pay in a timely manner and returned check fees.

I, _____have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)