CONSENT TO CHIROPRACTIC CARE

I hereby authorize Ogle Chiropractic and Rehab Center, LLC and its licensed doctors and assistants, based on my complaints and the history I have provided, to provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on the practice doctors to make those decisions about my care based on the facts then known, that they believe are in my best interest.

The specifics of the doctor's recommendation will be explained during this Report of Findings and any subsequent examinations and significant changes in your diagnosis or treatment plan.

Based on current findings, the practice doctors have discussed my treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the cost of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, the practice has proved me with specific pamphlets and other literature and the practice doctors have answered my questions regarding the planned treatments and course of care that I will receive. The practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any addition al questions that I may have at any time.

I have also advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjustment or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetected by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic or medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the practice.

_____

Patient's Printed Name

_____

Patient's Signature

Doctor's Notes:
Patients counseled by:

_____

Signature of doctor