OAK STREET CHIROPRACTIC CARE, LTD.
2 East Oak Street, Suite 1605
Chicago, IL 60611
oakstreetchiropractic.com
(312) 944-6269

Informed Consent to and Disclosure of Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and various modes of physiological therapeutics, on me (or on the patient named below, for whom I am legally responsible) which are recommended by Dr. Ron Reiss (the "Doctor") and/or other licensed doctors of chiropractic, who now or in the future, render treatment to me while employed by, working for, associated with or serving as back-up for the Doctor.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. These complications include, but are not limited to: fractures, disc injuries, dislocations, sprains, muscle strain, increased symptoms and/or pain, no improvement of symptoms and/or pain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains/separations. Some types of spinal manipulations (chiropractic adjustments) performed on the neck, occurring in extremely remote conditions, have been associated with injuries to the arteries of the neck, leading to or contributing to serious complications, including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s), which the doctor feels at the time, based upon the facts then known, are in my best interest.

I further acknowledge that no guarantees or assurances have been made concerning treatment results or outcomes, I have had the opportunity to discuss with the doctor the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment consent. By signing below, I state that I have weighed the risks involved in undergoing treatment, and have decided that it is in my best interest to undergo the chiropractic treatment plan that has been recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE

_____

Patient's Name (printed)

_____ _____

Patient's Signature **Date**

_____ _____

Representative's Signature **Date**

_____ _____

Witness to Patient Signature **Date**