SPINAL SOLUTIONS
101 1st Avenue East
Newton, Iowa 50208
Phone: 641-791-2323 Fax: 641-791-2229

PROCEDURE CONSENT

I understand and am informed that the professions of medicine, osteopathy, dentistry, chiropractic, physical therapy and rehabilitation, nursing, optometry, pharmacy, podiatry, and others have known risks which may include death, brain, damage, paralysis, loss of organ function or limb function.

I understand that as in the practices mentioned above, the practice of chiropractic and decompression therapy (physical medicine) there are risks including but not limited to fractures, disc injuries, strokes, dislocations,
sprains, and failure to produce the results I seek.

I do not expect the doctor to be able to anticipate and explain all risks and complications, as some may be unforeseen. I wish to rely upon the staff members of this clinic to exercise judgment during the course of the procedures administered to me based upon the facts then known to them, and to do their best to act in my self interest.

I am aware that I have the right to request information regarding other treatment options which may include but are not limited to surgery, injections, medications, physical therapy, manipulation.

I have read or have had read to me the information above and I have had the opportunity to ask questions about its content and by signing below I agree to continue with the treatment prescribed to me of the person for whom I am legally responsible for, by the Doctors and staff members of the Spinal Solutions Clinic. 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.

Patient signature: _____ Date: _____

Patient Name (Printed): _____

Legal Guardian Signature: _____ Date: _____
(If patient is under 18 years of age)