Ferguson Family Chiropractic, PLLC~ 653 Plank Road ~ Clifton Park, NY 12065

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective and the method that will be used to attain it. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between **structure** (primarily the **spine**) and **function** (primarily the **nervous system**) as that relationship may affect the restoration and preservation of health. One disturbance to the nervous system is called a **vertebral subluxation** - when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment** - the specific application of forces to the spine done by hand or handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

Initials_____I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my/child's health. I/we may be adjusted in a semi-private room where private information I offer may be overheard by others. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct spinal misalignments/nerve stress (vertebral subluxations).

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved parties.

Initials _____ I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I/my child is not pregnant. Date of last menstrual period (___/____/_____)

Initials _____ I grant permission to be called, texted and/or e-mailed to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my/child's health concern(s).

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The **benefits, risks and alternatives** of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Patient Name	Signature of Patient or Guardian	Date