WINFIELD CHIROPRACTIC
Dr. Brad Swanson, D.C. & Dr. Douglas A. Swanson, D.C.
1913 E. 19th Ave. Winfield, Kansas 67156
(620)221-1990

INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

To the patient: you have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold you consent to the procedures.

I, hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy, such as those listed below, and other diagnostic testing on me (or the patient named below, for whom I am legally responsible) by Dr. Dr. Brad Swanson, D.C. or Dr. Douglas A. Swanson, D.C. or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctors of Chiropractic named below.

• Decompression Therapy • Fascia/Percussion Therapy • Ultrasound • Accupuncture • EB Pro/Ion Cleanse Therapy	• Nutritional Recommendations • Interferential Muscular Stimulation (IMS) • Diathermy Therapy • Rehabilitation Exercises • Kinesio-Taping Methods

The above named procedures are considered "Wellness Care/Corrective Care" in our office and they may or may not be considered to be investigational or experimental at this time in the State of Kansas. By signing this form I acknowledge that I desire to have these procedures performed at this time and in the future as my treatment of choice. I also acknowledge that none of the above procedures are diagnostic in nature and are not to be considered a diagnosis for any ailment, but rather a therapeutic recommendation and alternative-adjunctive wellness/corrective treatment only.

If at any time, I decide to decline these statements, I will do so in writing in advance of the treatments and present the written document of decline of these specific treatments to Winfield Chiropractic or to Dr. Brad Swanson, D.C. or to Dr. Douglas A. Swanson, D.C.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain or no improvement in symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guaranties have been made to me concerning the results intended from the treatment.

By signing below I acknowledge that I have read or have had read to me the above consent. By signing below, if I proceed with treatment, I consent to the treatment plan and I intend this consent to cover the entire course of my care and for any future condition(s) for which I seek.

To be completed by the patient, or patient's representative, If necessary, e.g., **if the patient is a minor or physically or legally incapacitated**:

Print Name:_____

Relationship/Authority to patient:_____

Signature of Patient/Representative_____ Date_____

Witness:_____