Lancaster Chiropractic

AUTHORIZATION FOR CHIROPRACTIC TREATMENT AND INFORMED CONSENT

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The practice of chiropractic medicine involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease.

Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health.

The Patient is encouraged to ask questions!

I, the undersigned Patient, understand there are risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, and treatments by Lancaster Family and Pediatric Chiropractic. I hereby authorize Dr. Beth A. Lancaster, and whomever she designates her assistants, to administer such treatments, therapy, and manipulations as she deems therapeutically necessary, to me or my minor child. I give my informed consent to receive chiropractic medicine from Lancaster Family and Pediatric Chiropractic.

I also understand that no doctor can or should guarantee any “cure” for any course of treatment and that no spinal correction therefore can be guaranteed. If any pre-payment is made, and you discontinue care for any reason, any unused portion of the pre-payment is refundable.

Records Release Authorization

I hereby authorize Dr. Beth A. Lancaster to release all medical information acquired from my examination, illness, or treatment to any doctor, insurance carrier, or attorney.

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Patient Signature (or Guardian Signature) Date

_____ _____

PRINTED Name (First/Last) Date of Birth