Active Chiropractic & Rehabilitation, LLC
Patrick Bourlon, DC
233 SE Washington Street Hillsboro, OR 97123 (503) 648-1088 (503) 648-0748 fax

# DISCLOSURE & CONSENT CHIROPRACTIC ADJUSTMENTS AND CARE

**TO THE PATIENT:** You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic 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 disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/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 Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

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 of 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 guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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.

---

To be completed by the patient:

_____
Print name

_____
Signature of patient

_____
Date signed

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

_____
Print name of patient

_____
Print name of patient's representative

_____
Signature of patient's representative

as:_____
relationship or authority of patient's representative

_____
Date signed

---

To be completed by doctor or staff

_____
Witness to patient's signature

_____
Translated by

To be completed by doctor or staff

_____
Date

_____
Date