**Informed Consent**

I hereby request and consent to the performance of chiropractic adjustments, computerized range of motion, examination procedures, including diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by any licensed doctor of chiropractic who treats me at Overlake Chiropractic Clinic. I am responsible for informing the doctor if I am pregnant or may be pregnant PRIOR to having x-rays.

I will have an opportunity to discuss with the doctor at the Overlake Chiropractic Clinic and/or other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that patients experience and audible “pop” during a manual adjustment and this is a normal part of treatment. Overlake Chiropractic doctors perform full spine adjustments, which may include areas other than my chief complaint, in an effort to correct the biomechanics of my spine as a whole.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risk and complications of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest. According to research the probability of serious injury is 1:1,000,000 or about the same risk as being struck by lightning. I understand that 40% of non-symptomatic patients have disc herniation’s, which may exist in my spine and become symptomatic whether or not I receive treatment.

I have read, or have had read to me, the above consent and I understand. I will also have an opportunity to ask questions about its content, and by signing below I agree to the above names procedures. I intend this consent from to cover the entire course of treatment for my present condition and for any future condition(s) and for which I seek treatment.

**To be completed by patient:**

**Patient Name: Date:**

**Signature:**

**\*\*To be completed by Patient’s representative if patient is a Minor or Physically/Legally Incapacitated\*\***

**Patient Name: Name of Representative:**

**Date: Signature of Representative:**

**Relationship or Authority to Patients Representative above:**

## Overlake Chiropractic

## 15615 Bel-Red Rd. Ste A Bellevue, WA 98008 (P) 425-883-0133 (F) 425-702-6366

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