Informed Consent

Terms of Acceptance

When a person seeks Chiropractic care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment- An adjustment is a specific application of forces to facilitate the body's correction of the vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine. The doctor will walk through this process with you step by step.
Health- A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.
Vertebral Subluxation- A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nervous system function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
The Goal of Chiropractic Care- The goal of Chiropractic care is to detect, analyze, and adjust vertebral subluxations to allow the body's innate ability to express its maximum health potential.
Diagnosis- We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinals examination, we encounter non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Consent to Care

I do hereby authorize the Doctors of Mitchell Family Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, Chiropractic spinal adjustments and other Chiropractic procedures, including any other procedure that is
advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and 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, disk injuries, strokes, dislocations and sprains. 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 upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature_____ Date _____

(If under age 18) Parent's signature_____

Consent to evaluate and adjust a minor child:

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature_____ Date _____

Consent to use picture and/or first name in office or social media:

I, _____give consent for my picture and/or first name to be used in office (example but not limited to: Patient of the Month) or on social media for Mitchell Family Chiropractic

Signature_____ Date _____

Insurance Information:

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances.

Signature_____ Date _____

Doctor Information:

Print__Jessica Mitchell, DC_____ Signature_____
Date _____