EHLE
ROBERT EHLE, D.C., P.A.

INFORMED CONSENT TO CHIROPRACTIC AND/OR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic manipulation(s), acupuncture, and any other procedures, including exams, diagnostic x-rays, biofeedback and physiotherapy techniques (e.g., massage, electrical stimulation, decompression, myofascial release, and ultrasound) on me (or on the patient named below for which I am legally responsible), which are recommended by Robert Ehle, D.C. and/or other licensed doctors of chiropractic who render treatment to me while serving as backup for Dr. Ehle.

Although spinal manipulation is considered to be one of the safest most effective forms of therapy for musculoskeletal problems, the possible risks and complications associated include, but are not limited to: sprains, dislocations, fractures, disc injuries, paralysis and strokes (a very rare occurrence). Acupuncture is a safe method of treatment, but it also may have side effects, such as, but not limited to: bruising, numbness or tingling near the needling sites, dizziness, fainting, infection, nerve damage and organ puncture, including lung. I do not expect Dr. Ehle to be able to anticipate and explain all risks and complications, but based on the facts then known, I wish to rely on his judgment during the course of the procedures, which he feels is in my current best interests.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I understand that I am responsible for monitoring my own condition throughout the treatments and will inform Dr. Ehle of any unusual symptoms that might occur.

I have had the opportunity to discuss with Dr. Ehle and/or with the office personnel the nature, purpose and risks of chiropractic treatment and other recommended procedures and have had my questions answered to my satisfaction **prior to my signing** this consent form. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have freely decided that it is in my best interest to undergo the chiropractic treatment recommended and hereby give my full consent to treatment. 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.

_____
Printed name of Patient

_____ _____
Signature of Patient or Guardian (if minor) Date

_____ _____
Witness to Patient's Signature Date