PROSPER CHIROPRACTIC & WELLNESS CENTER
221 N. Preston Rd. Ste. D
Prosper, TX 75078

Consent to Treat

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Prosper Chiropractic & Wellness Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

Regarding diagnostic x-rays (if necessary), I acknowledge that I am not pregnant, nor am I trying to get pregnant. X-ray radiation is dangerous to a developing fetus. If I suspect that I may be pregnant, I have made the doctor aware of this so that x-rays are not performed.

The date of my last menstrual cycle is: _____/_____/_____

Acknowledgement

(TO BE COMPLETED BY PATIENT)

I, _____, have read and fully understand the above statements.
I have been provided an opportunity to discuss my right to privacy.

Print Name: _____

Signature: _____ Date: _____

(TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED)

Signature of Representative:_____Date:_____

Relationship of Authority or Representative:_____