

# **Informed Consent for Chiropractic Treatments and Care**

*Back in Motion  
1453 Sixth Street  
Brookings, SD 57006  
605-692-2225*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or on the patient named below, for whom I am legally responsible) by Rodney Brandenburger, DC 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 back-up for Rodney Brandenburger, DC.

I will have an opportunity to discuss with Rodney Brandenburger, DC and/or with office clinic personnel the nature and purpose of chiropractic adjustments and other procedures before they are administered.

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, disk injuries, strokes, dislocations, 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.

I further agree that all doctor's notes and patient records may be sent to my personal health insurance and/or any other responsible insurance carrier, including workers' compensation or auto insurance, or to attorney's or other parties which request records in order to determine payment on my behalf to Rodney Brandenburger, DC.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**If patient is a minor or physically or legally incapacitated:**

Patient's Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian Signature \_\_\_\_\_