**SHAPERO CHIROPRACTIC**
CHIROPRACTOR TO THE USF ATHLETIC DEPARTMENT

300 MONTGOMERY STREET - SUITE 204
SAN FRANCISCO, CA 94104
(415) 397-2544

# 441Chiropractic Informed Consent to Treat Form

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with the doctor of chiropractic named below.

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.

I understand and am informed that, as in the practice of medicine, results are not guaranteed and there is no promise to cure. I further understand, and I am informed that, as with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including but not limited to muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement if symptoms fractures, disc 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other healthcare modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However prorated fees for unused, prepaid treatments will be refunded if you wish to cancel treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to; over the counter analgesic, prescription drugs such as anti-inflammatories, muscle relaxants, steroid injections, and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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 condition(s) for which I seek treatment.

Patient Name_____ Date _____

Patient Signature_____ Date _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Doctor of Chiropractic Name: **Daniel Shapero**

Doctor of Chiropractic Signature _____ Date: _____