



Fly Chiropractic

**CHIROPRACTIC INFORMED CONSENT TO TREAT**

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy/physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated 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, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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 procedures.

I understand that chiropractic adjustments and supportive treatment are 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, I understand and am informed that, as is 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 of symptoms, burns from heat lamps, ice or heating devices, 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 on the doctor to exercise judgement 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 understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 I wish to cancel the treatment.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR'S NAME:  
SALLY GIORDANO, DC. #CH14741

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

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**CONSENT TO TREAT MINOR**

I hereby authorize Dr. Name, D.C. and whomever he may designate to administer chiropractic care as deemed necessary to my \_\_\_\_\_ (indicate relationship of child)

Name of Child: \_\_\_\_\_

**Treatments that may be provided:** Adjustments, Therapeutic Exercises, Electrical Muscle Stimulation, Hot/cold pack therapy, Mechanical Traction, Ultrasound, Manual Therapy/Myofacial Release/Trigger Point therapy, Dry Cupping therapy, Hydrobed therapy, and Strapping. \_\_\_ times per week from initial visit \_\_\_\_\_ until \_\_\_\_\_.

Information concerning sexual activity, alcohol use and/or substance abuse will not be disclosed to you the parent/guardian without consent of your child. Any information concerning suicide ideation or homicide ideation will be disclosed to you immediately. This information is regulated by Florida State Law and HIPAA.

Guardian Name: \_\_\_\_\_ Guardian Signature: \_\_\_\_\_