INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND GENERAL INDEMNITY

I _____, the undersigned, hereby request and consent to the performance of chiropractic treatment (or on the patient for whom I am legally responsible) by the chiropractor and/or anyone registered as a chiropractor working in this office authorized by same.

I am aware and consent that in order to proceed with an effective treatment, my health status must be evaluated by means of an interview and the performance of clinical tests. I am further aware of my right to have a person of my choosing present during certain physical examinations and my right not to remain disrobed any longer than is required for accomplishing the examination.

I understand that, as with any health procedure, there are certain risks that may arise during chiropractic treatment. The risks associated with joint manipulation and mobilization are typically minor if they occur, possible side effects include mild to moderate discomfort, autonomic phenomena such as dizziness, headaches and post treatment discomfort. More severe complications are extremely rare but have been reported, such as fractures, dislocations, disc herniation or progression of neurological symptoms and stroke. Other chiropractic treatments that this practice may utilize are dry needling therapy, soft tissue therapy, strapping and bracing. Risks associated with these therapies include bleeding, bruising, infection, lung puncture, pain, autonomic phenomenon, skin irritation and discomfort. Should I experience any side effects, I confirm that I will immediately notify my chiropractor and inform them of same. My failure to raise any concern will create the assumption that I am satisfied with the service provided and further indicates that I am not experiencing any side effects to the treatment provided.

Protection of Personal Information Act:
I understand my chiropractor's legal duty and herewith consent to the disclosure of my diagnosis to the medical schemes, other medical professionals and support staff in the employ of this practice for purposes of reimbursement of my account, or referral. I acknowledge that once my information is with the relevant medical scheme, Dr Kate Dinkelmann Chiropractic has no further control over the management and utilisation of the information and understand that the medical scheme will take responsibility for any further disclosure of such information.

Patient Initial

I also hereby accept full financial responsibility for this account until it is settled in full. I confirm that all details provided are both true and correct. It has further been explained to me the costs involved in chiropractic treatment and agree to said costs. I also understand that should I not cancel an appointment within twenty four (24) hours of said appointment I may be invoiced for the full amount. I acknowledge that should I fail to pay the account, I will be liable for all legal fees, on an attorney client scale, incurred in the collection of the outstanding account.
I further understand that access to the premises of the chiropractor and the use of all facilities is done at my own risk and I hereby indemnify the owner of the premises, the chiropractor and all employees in their service, agents or temporary workers against any liability for loss or damage of any kind whatsoever.

I acknowledge that I have read this consent and I have been offered the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general, the treatment options and recommendations for my condition, costs and the contents of this consent. I also understand that results are not guaranteed. I intend for this consent to apply to my present treatments and, in future, should it occur that my condition changes during the course of my treatment, I will participate in any decision affecting my personal health and course of treatment. I further note my right to withdraw my consent at any time for any specific treatment.

_____ _____

Patient's Signature DATE
(Guardian of patient should the patient be younger than eighteen)

_____ _____

Witness Signature DATE