Thompson Chiropractic
& Acupuncture

Dr. Tommy R. Thompson
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(812) 577-0289

Chiropractic, Acupuncture, and Nutrition Informed Consent Form

I admit that I have encountered symptoms that have prompted me to seek medical treatment. This is directed me to chiropractic and acupuncture and/or nutritional supplementation for alleviation of those symptoms or conditions.

Whether or not I have been treated by a chiropractic physician, an acupuncturist, or a nutritionist before, I acknowledge that I have been informed by Dr. Thompson and/or his staff by verbal or written, visual or other forms of communication of the inherent potential of risks of any medical treatment, specifically chiropractic, acupuncture, or nutrition, and depending on my medical history, further complications, side effects or risks possible. I have been made aware of the procedures involved in my treatment at this clinic and voluntarily accept the treatments I have been or will be given and agree to its necessity in the treatment of my diagnosis or injuries.

I do admit and recognize that all health care procedures, including those used at the clinic, have risks associated with them. Risks, though rare, associated with chiropractic, acupuncture, or nutrition treatments, including adjustments, may include temporary minor aggravation of symptoms, pain, or even more serious resultant conditions. I hereby accept the risks associated with my treatment with Dr. Tommy R. Thompson, and release Dr. Thompson of any liability for any injury or loss directly related to care I have received at this clinic.

I have fully cooperated with Dr. Tommy R. Thompson in providing a complete and accurate personal medical history including any and all medications prescribed or not, illegal or not, herbal or supplemental. I take full responsibility for non-disclosure of any relevant medical information.

By signing this form, I am giving consent, acceptance, and understanding of the terms and information provided within this form. I understand that there are no guarantees in treatment success and that by maintaining my presence and continued appointments, I consent to the benefits or treatment and assume responsibility for any risks associated with my treatment.

_____

Print name

_____ ___ _____

Patient signature Date