Lakernick Brain Center, Inc.
Financial Policies
Informed Consent For Chiropractic Function Neurology Treatment

I _____consent to the performance
(Responsible parties name)

of chiropractic function neurology treatments and any other associated procedures; physical examination tests, diagnostic x-ray, physio-therapy, physical medicine physical therapy procedures, massage etc., on me by the doctor of chiropractic and or his assistants and/or his other licensed practitioners with Lakernick Brain Center, Inc.

**I understand, as with any health care procedures, that certain complications may arise during chiropractic functional neurology treatments.

> Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) at Lakernick Brain Center, Inc. and/or with office personnel, the nature and purpose, as well as, risks of chiropractic functional neurology treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. I have read (or have had read to me) the above explanation of the chiropractic function neurology treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic functional neurology and neurology procedures at this health care clinic. I have decided, freely and voluntarily, that it is in my best interest to receive chiropractic functional neurology care I give my consent to that treatment. This consent will cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Patient Name (Print)

_____ _____
Signature of Patient or Representative Date

_____
Witness Signature