

INFORMED CONSENT TO PARTICIPATE IN EXAMINATION, TREATMENT AND ACTIVE REHABILITATION



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I (We) _____, hereby consent to the performance of examination and treatment on me or by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists, licensed massage therapist and/or trained employees who may be employed by or engaged in practice at Prevention and Wellness Center, Inc.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures, diagnostic/laboratory testing and chiropractic treatment (manipulation/adjustment). I understand that neither medical treatment nor chiropractic is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made expected but rather I wish to rely on the doctor to choose and recommend the best course of treatment based upon facts known and that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read over the above information that has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend for this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

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ACTIVE REHABILITATION**

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is a pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem
2. Establish a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyles.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company and/or attorney, if it is applicable.

_____ Patient's Name (print)	_____ Patient's Signature
_____ Date	_____ Relationship of authority if not signed by Patient