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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to appropriate chiropractic case management for me (or the person named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by or serving as back-up for the doctor of chiropractic named below.

I understand that the purpose of chiropractic care is to optimize health by facilitating neurological and biomechanical integrity, which allows maximum expression of the body's innate recuperative abilities. No guarantees of cure of any ailment have been implied or given.

Chiropractic adjustments are exceedingly safe when performed correctly. However, I understand there are some risks to care including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain every risk and complication. I will rely on the doctor's best judgment to protect my best interests. I understand that a small force is introduced into the spine, either by hand or an adjusting instrument, during a chiropractic adjustment that may lead to temporary discomfort. This is normal and is usually minor.

I have had the opportunity to discuss with the doctor of chiropractic any questions, comments, or concerns I have about the care I will receive.

I have read, and/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 form to cover the entire course of care now and in the future. I understand I am free to discontinue care at any time.

Patient name (print)

Patient/ Guardian's signature and date