AMUNDSON CHIROPRACTIC HEALTH SERVICES, LLC
104 NW 7 HWY, STE G
BLUE SPRINGS, MO 64014

CONSENT TO TREATMENT

CHIROPRACTIC CARE:

I, _____, hereby authorize and consent to the performance upon me of the treatment of Chiropractic by Dr. Jennifer Amundson, or any of the physicians who may become associated with them in the practice of Amundson Chiropractic Health Services, LLC. Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that is responsible to let you know:

1. Risk of stroke is reported to be 1 in 5-8 million or so…and the cause has yet to be determined.
2. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported.
3. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both, clinically and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

CONSENT TO TREAT WITH ACUPUNCTURE:

I also hereby authorize and consent to the performance upon me of the treatment of acupuncture by Dr. Jennifer Amundson, or any of the physicians who may become associated with them in the practice of Amundson Chiropractic Health Services, LLC and to the employment of such assistants as they may deem necessary to carry out such treatment. Acupuncture has been explained to me as a chiropractic specialty treatment performed by the insertion of special needles (with or without the application of small pulses of electric current to the needles) through the skin into underlying tissues at certain indicated points on the surface of the body, for the purpose of seeking the alleviation, of an undetermined time, of pain or of bodily disorders. Other methods of acupuncture treatments may include: teishin, activator, ion balls or any other means by which acupuncture points may be stimulated/sedated to cause a physiological effect on me as deemed necessary by the doctor.

POSSIBLE HAZARDS OF ACUPUNCTURE NEEDLE USE: may include, but not be limited to: Skin irritation & Redness, Bruising, Bleeding, Infection of the skin or other bodily tissues and/or organs, Pneumothorax (Collapsed Lung) and Needle breaking off under (which would need to be removed by a medical practitioner). All needles in our clinic(s) are brand new, sterile packaged needles. Needles are NEVER re-used. All needles are discarded into a medically approved sharps container (Such as used in Hospitals and other types of Doctor's offices for their needles). I am aware that it is IMPERATIVE that while I am retaining needles that I am to remain completely still. Any moving or getting up and around could cause severe injury to me from needles being bumped, hit, embedded, etc…Therefore; I agree to remain still and without motion.

I am aware that the use of acupuncture is not a common practice in this country. The nature and purpose of my treatment and the hazards and potential complications have been explained to me and no warranty or guarantee has been made to me as to any result of a cure.

I have been advised that acupuncture is not covered by Medicare policies and, thus, Dr. Amundson is not a participating physician. I understand that I am responsible for the payments of all the professional services rendered by her at the time of service.

Over Please --->

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I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor. I consent to the care recommended by my chiropractor and extend this consent to include all doctors of the Health & Nutrition Center. This consent applies to all present and future care for me and my family.

NUTRITION:

I specifically authorize Dr. Jennifer Amundson to do health analysis and to develop a natural, complimentary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease.

I understand that this is not a method for "diagnosing", "preventing", or "treating" any disease(s) or condition(s) including, but not limited to: conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional health, nutritional or dietary programs recommended, but rather I understand that it is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I understand that I am to adhere to the program guidelines. These guidelines have been fully laid out before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success.

I have read and understand the forging. This permission form applies to subsequent visits and consultations.

CONSENT FOR MINOR:

I (we) have legal custody/guardianship of said minor _____ and do hereby authorize the doctors at Amundson Chiropractic Health Services, LLC to treat the above said minor for examination, x-rays, and treatment deemed advisable by a licensed chiropractor. This authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agents to give specific consent to any and all such diagnosis and treatment which the chiropractor deemed medically necessary. This authorization allows doctor to treat without parent/guardian present. This authorization will be in effect until 12/31/____ unless revoked by written communication.

Patient name:_____

_____ _____

Patient/Guardian Signature **Today's Date**

Over Please --->