Five Star Chiropractic, LLC
207-776-2722
DrEm@FiveStarWellnessChiro.com

FIVE STAR CHIROPRACTIC

Consent to Chiropractic Care

I, _____ , being eighteen years or older, do understand, substantiate, and authorize the following:

The purpose of chiropractic services is to promote natural health through the reduction of intervertebral joint restrictions (a lesion or dysfunction in a joint or motion segment in which alignment, movement integrity and/ or physiological function are altered, although contact between joint surfaces remain intact). The result of this can additionally cause alteration of nerve function and interference to the transmission of the nerve impulses, resulting in a lessening of the animal's innate ability to express its maximum health potential.

Like most health care procedures, chiropractic treatments carry with it some risks. Unlike many such procedures, the serious risks associated with chiropractic care are extremely rare. Similar conditions across patients may respond differently to the same chiropractic care. In rare cases, underlying physical defects, deformities or pathologies, even certain health-challenged individuals may render the patient susceptible to injury.

It is the responsibility of the patient to make known, or to learn through health care procedures when they are suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic.

I hereby give my consent to the performance of diagnostic tests, procedures, and chiropractic treatment or management of my condition/s.

Chiropractic care is proven to be one of the safest and most effective forms of healthcare available.

- The provider/s treating and/ or managing my chiropractic condition/s is/ are a Doctor of Chiropractic, licensed in the care of humans, and is therefore qualified to perform chiropractic services.
- Chiropractic care IS NOT intended to replace appropriate medical care but intended to be used concurrently.
- I have read and understand the scope of the chiropractic care I am about to receive. I understand and acknowledge and agree with the College of Chiropractors description of Chiropractic as follows: "Chiropractic is the examination, diagnosis, and treatment of humans through manipulation and adjustments of specific joints and cranial sutures." Chiropractic DOES NOT include: dispensing of medications, performing surgery, injecting medications, recommending supplements or replacing traditional medical care.
- I hereby authorize and give my consent to the performance of chiropractic tests, procedures, and chiropractic treatment and/or management of my chiropractic condition/s.

Signature: _____ Date: _____

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Consent to Payments

Payment is expected to be paid in full at the time of each service. If payments are not made, Five Star Chiropractic LLC holds the right to stop rendering services. If a check is returned due to insufficient funds in the account, a $35 penalty fee will be charged to the account.

I, _____ , have read and understand the above policies.

Patient signature: _____ Date: _____

Cancellation Policy

We know your time is valuable, and ours is too. Out of respect for our staff and other clients, we ask you give us at least 48-hour notice if you need to cancel an appointment.

The first time a client misses / cancels an appointment, we will make note in your file with no charge. All following missed appointments will incur a fee of 25% of scheduled services.

Patient Signature: _____ Date: _____