

# ChiroCare Plus, P.C.

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Dennis J. Gesualdi, DC, CCSP, FIAMA  
Practice of Chiropractic and Acupuncture

## Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic treatment (adjustments or manipulations) and/or acupuncture treatment and any other associated procedures: physical examination, tests, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named below, and/or other assistants or licensed practitioners within this office.

I understand, as with any health care procedure, that there are certain complications that may arise during chiropractic or acupuncture treatment. Those complications may include but are not limited to: bruising, soreness, fractures, disc injuries, dislocations, muscle strain, Homers' Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation 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 or predict all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of my treatment and procedures, have disclosed to the doctor all known medical conditions I have had or may currently have, and have discussed any medications I currently take. I have had my questions answered to my satisfaction, and understand that specific results are not guaranteed.

I understand and agree that some services the doctor may provide may or may not be covered by my insurance company.

By signing below, I state that I have been informed and have weighed the risks involved in chiropractic and acupuncture treatment at this office. I have decided that it is in my best interest to receive chiropractic treatment, and I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions for which I may seek treatment. I understand I may revoke this consent at any time in writing, effectively ending any course of treatment I may undergoing at that time.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Treating Doctor

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor or Office Representative

\_\_\_\_\_  
Date