FULL MOTION INTEGRATED MEDICINE
CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or other licensed doctors who now or in the future work at the clinic or office listed below.

I will have the opportunity to discuss with the doctor(s) the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor(s) to exercise judgment during the course of the procedure which the doctor(s) feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that the doctor(s) will also explain the risks associated with my refusal of treatment.

I have read, 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 treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature______________________________ Date _________________

Witness Signature _____________________________________ Date__________________

Full Motion
INTEGRATED MEDICINE

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Provider Statement of Patient/Client Rights and Responsibilities

Patients/Clients have the **Right** to:

- …be treated with dignity and respect.
- …fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- …their treatment and other patient information kept private. Only by law may records be released without patient permission.
- …access care easily and in a timely fashion.
- …a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- …share in developing their plan of care.
- …the delivery of services in a culturally competent manner.
- …information about the organization, its providers, services, and role in the treatment process.
- …information about provider work history and training.
- …information about clinical guidelines used in providing and managing their care.
- …know about advocacy and community groups and prevention services.
- …freely file a complaint, grievance, or appeal, and to learn how to do so.
- …know about laws that relate to their rights and responsibilities.
- …know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

Patients/Clients have the **Responsibility** to:

- …treat those giving them care with dignity and respect.
- …give providers the information they need, in order to provide the best possible care.
- …ask their providers questions about their care.
- …help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- …let their provider know when the treatment plan no longer works for them.
- …tell their provider about medication changes, including medications given to them by others.
- …keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- …let their provider know about their insurance coverage, and any changes to it.
- …let their provider know about problems with paying fees.
- …not take actions that could harm others.
- …report fraud and abuse.
- …openly report concerns about quality of care.
- …let their provider know about any changes to their contact information (name, address, phone, etc).
- …understand and help develop plans and goals to improve their health.

I have read and understood my **Rights** and **Responsibilities**.

Patient Signature____Date_________________