Allied Chiropractic

Dr. Edward Wilkinson, D.C.

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NOTICE OF INFORMED CONSENT AND AUTHORIZATION OF CARE

Patient Name:

Date of Birth:

SSN:

I, ___________________________________, hereby authorize Dr. Edward Wilkinson, D.C., and whomever they may designate as their assistants, to administer the following: Consultation, examination, diagnostic procedures, physical therapeutics, X-rays, spinal manipulation, joint mobilization, acupuncture, etc., as are considered therapeutically necessary on the basis of findings during the course of care. I understand that I should seek outside medical care for conditions including but not limited to: pathology, infection, fracture, cancer, and other forms of disease and illness; which may be out of the scope of chiropractic care.

Definition of Acupuncture: Acupuncture is the stimulation of acupuncture points by penetration of the skin by thin, solid, metallic needles, which are manipulated manually or by electrical stimulation. Needles are sterile and are disposed of after one use.

I understand that acupuncture treatment is an adjunct treatment not meant to replace traditional medical care. Possible complications include but not limited to: bruising, minor bleeding, infection, fainting, etc. Contraindications for acupuncture treatment are pregnancy, medical emergencies, malignant tumors or neoplasm, and bleeding disorders.

Section 32.1-45.1 (A) and (B), Code of Virginia (1950 as amended) provides that in the event of significant exposure (e.g. needlestick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis C Virus is considered to have been given by the patient and/or healthcare worker thereby granting Allied Chiropractic and staff to order such tests. Test results are confidential and can only be released in accordance with applicable laws.

I, ___________________________________, hereby certify that I have read and fully understand this informed consent and authorization for care, the reasons why care may be necessary, its advantages, possible complications, if any, as well as possible alternative forms of care, which were explained to me by my treating doctor. I will notify my

treating doctor of any change in my health status and I will follow the recommended treatment plan.

I,___________________________________, acknowledge that no guarantees or assurance of the results that may be obtained from the procedure has been given by the above named doctor, associates, or assistants.

I consent to such treatment and agree to hold my treating doctors and Allied Chiropractic free and harmless from any claims, demands, or suits for damages from any injury or complications that may result from such treatment.

PATIENT:_______________________________________(Print Name)

Signature:____________________________________Date:___________

Witness: _____________________________________Date:___________