SOLUTIONS INTEGRATED MEDICINE
CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other procedures, including various modes of physical therapeutic modalities and procedures, injections 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 named below and/or other licensed providers who now or in the future work at the clinic or office listed above.

I will have an opportunity to discuss with the medical professionals listed below, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of medicine, and 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. Injections: It is understood to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1. You may develop infection; 2. You may experience bleeding; 3. You may develop irritation at the injection site; 4. There may be skin changes; 5. You may develop bruising, redness or swelling; 6. The procedure may fail to reduce the pain symptoms

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 provider(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the provider(s) to exercise judgment during the course of the procedure which the provider(s) feels at the time, based upon the facts then known to him or her, is in my best interest. The providers named below can additionally explain the risks associated with my refusal of treatment, if that be the case.

Once services/supplies are rendered/delivered I understand there is no refunds for said services/supplies.

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.

Solutions Integrated Medicine Providers:

Fred Foshee D.O., Alicia Emery FNP, Molly Donnolly D.C., James L Warlick D.C.

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____