Sadon Chiropractic & Rehabilitation Center, PC
186 County Road 520, Suite 1
Morganville, NJ 07751

Informed Consent to Chiropractic & Physical Therapy Treatment

Medical doctors, chiropractic doctors, osteopaths, and Physical Therapists that perform manipulation are required to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, traction, ultrasound, hot packs, TENS unit, exercises, laser, and other therapeutic modalities may also be used.

Soreness: I am aware that, like exercises, it is common to experience muscle soreness in the first few treatments.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of complications from treatment, and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available

Reasonable alternative to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

I have read or have had read to me the above explanation of treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.
To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient Name (Print): _____

Patient/Parent/Legal Guardian Signature: _____ Date: _____

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself which my physician may consider necessary or advisable in the course of my examination and treatment.

Are you currently pregnant? _____ Yes ____ No

Patient/Parent/Legal Guardian Signature: _____ Date: _____