



# ALTERNATIVE HEALING CHIROPRACTIC CENTER

Dianna Loudenbeck, D.C.      Abby Stauss, D.C.

576 Donnelly Ave, Coos Bay, Or 97420

Telephone: 541-266-7543 Fax: 541-269-9408

## CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy by Dr. Dianna Loudenbeck and Dr. Abby Stauss. I understand that Dr. Loudenbeck's and Dr. Abby Stauss's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

Though chiropractic treatments are considered safe and effective methods of care, and rarely cause any problems, I understand that, like many other forms of health care, there are some risks, as any procedure intended to help may have complications. These can include, but are not limited to, soreness, inflammation, sprains, burns, dizziness and some worsening of symptoms. More serious complications are extremely rare and their association with spinal manipulation is debated. These can include fractures, dislocations, disc injuries, and stroke.

Alternatives to chiropractic treatment for common musculoskeletal conditions may include physical therapy, acupuncture, and medications such as muscle relaxers and anti-inflammatory drugs.

I understand that health care providers cannot guarantee the results of treatment. I acknowledge that no guarantee of the outcome of the chiropractic care I have requested has been made.

I reserve the right to opt out of any procedure at any time. I understand that I also have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Loudenbeck and Dr. Stauss has acted in reliance on this consent.

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Patient's Name

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Signature of Patient/Personal Representative/Guardian

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Date

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Description of Personal Representative's Authority