

**Sandia View Wellness** Consent for Chiropractic Treatment & Office Policies

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby request and consent to chiropractic care at Sandia View Wellness, including spinal adjustments/manipulations, mobilizations, soft tissue therapies, rehabilitative exercises, physiotherapy modalities (if applicable), and related procedures as recommended by my chiropractic doctor.

Nature & Purpose: Chiropractic adjustments restore joint function and support natural healing to reduce pain, improve mobility, and enhance well-being.

Benefits: Most patients experience pain relief, better range of motion, reduced stiffness, and improved function.

Risks & Complications: While serious issues are rare, possible risks include temporary soreness/stiffness, symptom flare-up, muscle strain, disc aggravation, rare fractures (e.g., in osteoporosis), nerve irritation, or extremely rare cerebrovascular events (estimated 1 in 1–5 million cervical adjustments). No guarantees of results are made.

Alternatives: Options include no treatment, rest/ice/heat, over-the-counter medications, physical therapy, massage, physician-prescribed care, injections, or surgery—each with its own risks/benefits.

I have discussed my condition, proposed treatment, benefits, risks, and alternatives with my chiropractor. I have had the opportunity to ask questions, and they have been answered to my satisfaction. I voluntarily consent to this care for my current and any future conditions unless I revoke it in writing.

**Office Policies – Missed Appointments & Cancellations**

**To respect other patients' time and maintain appointment availability:**

*24-hour advance notice is required for cancellations or rescheduling.*

*Late cancellations (<24 hours) or no-shows/missed appointments will incur a \$50 fee (or full service fee if higher).*

*This fee is the patient's responsibility (not billable to insurance) and must be paid before future appointments.*

*Repeated occurrences (more than 2 in 6 months) may require prepayment or affect continued care.*

I have read, understand, and agree to the above consent and policies.

Patient Signature (or Legal Guardian if minor): \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

If signed by Guardian/Representative: Relationship: \_\_\_\_\_