INFORMED CONSENT
Inner Light, Inc., dba Health Matters

- The information I have given this office is complete to the best of my knowledge. I authorize the doctors and staff of this clinic to administer such procedures and treatment as they deem necessary. They have implied no guarantees of cure.
- I consent to the examinations, x-rays and manipulations by the doctor. Further, I agree to any modality, therapy, or rehabilitation exercise that, in their opinion, is necessary in my case. I understand the staff is skilled in the use of many of the adjunctive therapies offered, although they might not be licensed or degreed as is provided and accepted by the Chiropractic Statutes of Georgia. I agree that under the guidance of my doctor the above mentioned properly trained staff may treat me directly.
- I am aware that x-rays taken of me and my clinical records are a permanent part of this clinic's permanent clinical record file, and as such, they may not be released from the office for a period of seven years. They are legally the property of this clinic.
- I understand that although rare, there may be certain risks inherent with the practice of chiropractic, physical medicine and rehabilitation. These risks include, but are not limited to, sprain/strain of area, spinal disc irritation and/or stroke.
- I understand that there are risks associated with the various adjunctive procedures offered in this office. These procedures include ice therapy, flexion/distraction therapy, myofascial release therapy, therapeutic exercises, and traction. Risks associated with these procedures include, but are not limited to, skin reactions, aggravations of the present condition, bruising, release of emboli, and deep vein thrombosis.
- I do not expect the doctor to anticipate, nor explain all of the risks, and/or complications that are possible, but I will rely on the doctors training and education to exercise professional judgment during the course of any procedure or protocol which he/she feels necessary based on the facts and diagnosis in my case.

Patient's Signature:_____ **Date:**_____

Witness Signature:_____ **Date:**_____

RELEASE OF RECORDS

- When necessary, and with this document acting as proper release thereof, I hereby give Health Matters permission to access and/or release my records to legal and/or other health care professionals, who present their request in a written and legal form.
- This consent noted herein will remain in effect throughout my active treatment program, for maintenance care and for future care.

Patient's Signature:_____ **Date:**_____

Witness Signature:_____ **Date:**_____

Consent.release