RISE CHIROPRACTIC AND WELLNESS

TERMS OF ACCEPTANCE & INFORMED CONSENT

Patient Name: _____
Date of Birth: _____

PURPOSE OF CARE & COMMUNICATION

The goal of Rise Chiropractic and Wellness is to support patients in improving their health, function, and quality of life through informed, collaborative care. We believe that informed decision-making, transparency, and open communication are essential components of ethical healthcare.

Some healthcare topics may be complex. This document is intended to clearly explain the nature of services provided, the scope of care, potential risks, and your rights and responsibilities as a patient.

Please read this document carefully. If you have any questions, you are encouraged to ask a member of our clinical team before signing.

GENERAL INFORMED CONSENT FOR CARE

By signing this form, I voluntarily consent to evaluation and care provided by licensed providers at Rise Chiropractic and Wellness, in accordance with professional standards, clinical findings, and my individualized care plan.

I understand that services offered at Rise Chiropractic and Wellness may include, but are not limited to:

- Chiropractic examination and spinal or extremity manipulation/adjustment
- Manual therapies and rehabilitative techniques
- Functional, lifestyle-based, and wellness-focused care recommendations
- Emotional or nervous system regulation–based care approaches
- Supportive or integrative wellness services
- Acupuncture and related modalities **(with separate acupuncture-specific informed consent, as required)**

I understand that providers may recommend additional or alternative services based on clinical findings, and that I retain the right to accept, decline, or discontinue care at any time.

RISKS, LIMITATIONS, AND RESPONSIBILITIES

I understand that:

- Chiropractic and related services are generally considered safe and effective when performed by licensed providers; however, **no healthcare service is completely risk-free**.
- Potential risks may include, but are not limited to: temporary soreness, stiffness, discomfort, aggravation of symptoms, bruising, dizziness, fainting, or fatigue.
- Rare but serious complications may occur depending on the service provided, individual health factors, or underlying conditions that may not be known at the time of care.

I understand that it is **my responsibility** to fully disclose relevant health history, medications, pregnancy status, diagnoses, and any changes in my health so that care may be provided safely.

I acknowledge that Rise Chiropractic and Wellness providers will not knowingly render care that is contraindicated based on the information available to them.

SCOPE OF PRACTICE & COORDINATION OF CARE

I understand that chiropractic and integrative wellness services are **not a substitute for emergency medical care** and do not include the diagnosis or treatment of conditions outside the provider's licensed scope of practice.

I understand that:

- Providers at Rise Chiropractic and Wellness offer specialized, non-duplicative healthcare services
- Providers may collaborate with or refer to other healthcare professionals when appropriate
- I may seek care from other healthcare providers concurrently

ACUPUNCTURE DISCLOSURE

If I elect to receive acupuncture services, I understand that:

- Acupuncture involves the insertion of sterile, single-use needles into specific points on the body
- Acupuncture carries its own specific risks, which will be explained to me
- **A separate Acupuncture Informed Consent is required and must be signed prior to my first acupuncture treatment**

Signing this form does **not** replace acupuncture-specific informed consent.

CARE OF MINORS

Consent to Evaluate and Treat a Minor

I affirm that I am the parent or legal guardian of the minor patient listed below and that I have the legal authority to consent to care on their behalf.

Minor's Name: _____

I have read and understand the information contained in this document and hereby grant permission for my child to receive care at Rise Chiropractic and Wellness consistent with this consent.

PATIENT RIGHTS

I understand that:

- I have the right to ask questions and receive explanations regarding my care
- I have the right to refuse or discontinue care at any time
- Consent may be withdrawn in writing at any time

ACKNOWLEDGMENT & CONSENT

By signing below, I acknowledge that:

- I have read and understand this Terms of Acceptance & Informed Consent
- I have had the opportunity to ask questions and receive answers
- I voluntarily consent to evaluation and care at Rise Chiropractic and Wellness

Patient / Guardian Printed Name: _____

Signature: _____

Date: _____