

INFORMED CONSENT FOR CHIROPRACTIC AND ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments, acupuncture treatment or any other treatments/procedures performed on me which are recommended by Dr. Chady F. Wonson.

Treatments/procedure(s) consented to may include but are not limited to physical examinations, chiropractic adjustments, acupuncture, acupressure, myofascial release, therapeutic exercises, infrared light, cold laser therapy, Chinese herbs, self-care coaching and nutritional counseling.

While rare, the possible complications from a **chiropractic adjustment** include but are not limited to fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy or costovertebral strains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to stroke or other serious complications. Dr. Wonson will carefully review my medical history, evaluate, and discuss with me if chiropractic treatment best fits my condition before application of any therapy.

During an **acupuncture treatment** Dr. Wonson may insert sterile, single-use needles on various acupuncture points on my body. On rare occasions acupuncture may have side effects such as dizziness, fainting, bruising, numbness or tingling near the needling sites that may last a few days. Slight bruising is a possible side effect of acupuncture. Highly unusual risks of acupuncture may include infections, spontaneous miscarriage, minor nerve damage, and organ puncture. Dr. Wonson complies with strict California state regulated protocols for needle usage and associated healing modalities.

Eastern Medicine uses and recommends **herbs and nutritional supplements** from plant, animal, and mineral sources which are traditionally considered safe. Herbs come in either capsules or granule (tea) forms. Some may have an unpleasant smell or taste, so capsule form may be easier to tolerate. Though rare, possible side effects from taking herbs or supplements include nausea, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. Taking large doses may be toxic. Some herbs may be inappropriate during pregnancy. I will notify Dr. Wonson if I may be pregnant or suspect that I am pregnant before each treatment begins. I understand that the recommended herbs/supplements need to be consumed according to Dr. Wonson's specific instructions. I will immediately notify Dr. Wonson of any unanticipated or unpleasant effects associated with the consumption of the herbal recommendations.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment, acupuncture treatment and other procedures provided by Dr. Wonson. I understand while this document describes the possible risks of treatments, other side effects may occur.

I do not expect the Dr. Wonson to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on Dr. Wonson to exercise judgment in my best interest during the treatments/procedures, which Dr. Wonson feels is correct at the time based upon the facts then known.

By voluntarily signing below, I show that I have read, or have had read to me, the entire contents of this Informed Consent Form. I understand the risks and benefits of chiropractic and acupuncture associated procedures. I have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment with Dr. Chady F. Wonson.

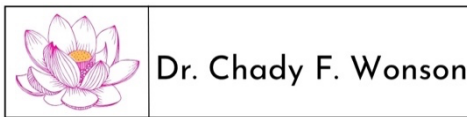
Signature of Patient or Personal Representative

Print name of Patient or Personal Representative

Date of Consent

Signature of Provider

Dr. Chady F. Wonson LAc, DC, CTN, CNC
Print name of Provider



INFORMED CONSENT FOR OFFICE POLICIES

Cancellation / Rescheduling Policy

My practice requires a 48-hour advance notice.

I understand there are times you must change or cancel your appointments. Your timely notice allows me the opportunity to offer your appointment to another patient. In this case, you will not be charged any fee. However, for appointments canceled or rescheduled with less than 48-hour notice, no matter the reason, you will be charged for the full visit fee. It is our office policy to keep your credit card on file which will be charged for no show or late cancellation fees.

Insurance Policy

I am not in-network for any insurance company and do not submit insurance claims. I do provide a Super Bill receipt with the appropriate insurance codes so that you can easily submit to your insurance for reimbursement.

Please take a moment to call your insurance provider or check their website for information about your particular plan's Out-of-Network Chiropractic coverage as well as any diagnosis that is excluded so that you are familiar with your plan's coverage in advance. As I am not a provider with Medicare or American Specialty Health, I do not provide specialized reports or narratives that they might require, so please familiarize yourself with their requirements and restrictions.

By voluntarily signing below, I show that I have read, or have had read to me, the entire contents of this Informed Consent Form. I understand the Dr. Wonson's office policies and agree to abide by them.

Signature of Patient or Personal Representative

Date of Consent