Mercy

Mercy Integrative Medicine

1. I, _____, give my consent and authorize Dr. _____ with associate(s) or assistant(s) of his/her choice and the staff of Mercy Integrative Medicine to perform the following procedure(s) on me, or on _____ the patient for whom I am authorized to consent:

_____

Acupuncture Auriculotherapy Chiropractic

_____

2. My chiropractor has explained the nature and purpose of the operation(s) procedure(s), reasonable alternative methods of treatment, the risks involved, the possible consequences, and the possibility of complications to me. I am aware the practice of chiropractic medicine is not an exact science, and I acknowledge that no guarantees have been made to me.

3. I consent to the performance of any other procedure(s) in addition to, or different from those now contemplated, whether or not arising from unforeseen conditions, which my chiropractor may consider necessary in the course of the procedure(s). Further, I authorize my chiropractor to make use of such additional services as necessary, including but not limited to or x-ray.

4. Medical Device. If relevant, I consent and authorize Mercy Integrative Medicine to release my name, address, telephone number and social security number to the manufacturer of the medical device that I receive, in accordance with applicable federal law and regulations. I further understand that the manufacturer may use this information to help locate me, if the manufacturer has a need to contact me with regard to this medical device.

I have had sufficient opportunity to discuss my condition and treatment with my physicians and his/her associates, and all of my questions have been answered to my satisfaction. I have read and understand this consent and all blanks were filled in. If I believe any part of this consent does not apply to me, or if I do not consent to them, I have drawn a line through the paragraph or sentence. I believe I have adequate knowledge upon which to base an informed consent to the proposed treatment.

Patient is unable to sign or consent because patient is ____ years of age, or patient is unable to sign because:

_____

_____ _____

Patient's Signature or Signature of Person Authorized To Consent for Patient

Relationship to Patient

Witness: _____ Date: _____ Time: _____

CONSENT TO SURGICAL, DIAGNOSTIC OR MEDICAL PROCEDURE AND ANESTHESIA
CONSENT TO CHIROPRACTIC PROCEDURE

Mercy Hospital St. Louis