Julie Esterly, DC NPI: 1770608713 Ph: 831-227-3148
Mail: 4055 Branciforte Dr. Santa Cruz, CA 95065
Office: 740 Front St, Ste 345A Santa Cruz, CA 95060

Informed Consent, Scope of Practice

I, _____, understand and acknowledge that Dr. Julie Esterly is not my primary care medical doctor. I am seeking her services on my own volition, as a secondary health service consultant and provider, and not as a primary care physician, for myself or my family.
My primary care physician is: _____ Ph: _____

Chiropractic Consultation and Treatment

I hereby request and consent to chiropractic adjustments and other procedures including examinations tests, diagnostic x-rays, alternative and complementary care, and physical therapy techniques for me (or the patient named below for whom I am legally responsible), which are recommended by Julie Esterly, DC, Doctor of Chiropractic. I have had the opportunity to discuss with Dr. Esterly the nature, purpose and possible risks of chiropractic adjustments and other recommended procedures, and have had my questions answered to my satisfaction.

I understand that, as with any health care procedure, there are certain complications which may arise during chiropractic adjustments/treatments. These complications include but are not limited to; fractures, disc injuries, dislocation, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, certain costovertebral strains and separations, as well as injuries to the arteries of the neck, which may contribute to serious complications. I do not expect the doctor to be able to anticipate all risks and complications, and wish to rely on Dr. Esterly to exercise judgement during the course of the procedures, which she feels at the time, based upon the facts known, are in my best interest. I understand that specific results are not guaranteed.

I have read (or had read to me) the above explanation. By signing below, I state that I understand Dr. Esterly's scope of practice, and have weighed the risks involved in undergoing treatment, and have decided that it is in my best interest to undergo chiropractic treatment. I have been informed of the risks and hereby give my consent to undergo treatment with Dr. Esterly.

I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____

Name of Patient Signature of Patient
Date

_____

Name of Patient's Representative Signature of Patient's Representative
Date