Brighi Chiropractic Center
7251 W 20th St. Bldg. F
Suite A
970-330-3556

Informed Consent

Patient: Please read and discuss any questions or concerns with the Doctor before signing this document.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me by Dr. Matthew C. Brighi.

I have had the opportunity to discuss with the Doctor and or office personnel the purpose and benefits of chiropractic care. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are generally beneficial and seldom cause any problems, I understand and I am informed that there are some risks to treatment. These include, but are not limited to fractures, disc injuries, stroke, dislocations and sprains.

I understand that chiropractic is not an exact science and that therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment I have requested and authorized. I have had the opportunity to read this form and ask questions. I herby consent to the proposed treatment.

Financial Policies

All payments are due in full at the time of service unless otherwise approved before treatment has been administered.

We are happy to verify any insurance benefits you may have, however verification is NOT a guarantee of coverage and Brighi Chiropractic Center is not responsible for claims not paid by the insurance company. The patient will be held responsible for all charges incurred during treatment.

Brighi Chiropractic Center does offer and recommend various extended care plans. Please inquire with any questions.

I have read and understand these policies. I agree to follow these policies as a patient of Brighi Chiropractic Center.

Name:_____ Date:_____