

Benessere Chiropractic, Massage and Fitness, LLC
295 W. Broadway
Eugene, OR 97401
Ph: (541)636-3358 F: (541)636-3098

Patient Informed Consent Form and Arbitration Agreement

I hereby request and consent to the administration of Chiropractic Manipulative Therapy, and other Chiropractic procedures, including examination, physiotherapeutic modalities (ultrasound, electrotherapies, stretching, exercise, etc.), physiological therapeutics (mineral/vitamin supplementation, homeopathic formulations, etc.) to me (or to the patient named herein, for whom I am legally responsible) by the licensed Chiropractors, Massage Therapists, and Chiropractic Assistants employed by Benessere Chiropractic Massage and Fitness, LLC

I understand and I am informed that in the practice of Chiropractic there are some risks of treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, aggravations of inflammatory conditions, sprains and strains. I do not expect the practitioner to be able to anticipate and explain all risks and complications. I will rely on the practitioner to exercise proper clinical decisions during the course of the procedure that the Chiropractor or practitioner feels is in my best interest, based upon the facts then known.

I further understand that there is no guarantee or assurance as to the result of any procedures. In the event the undersigned has a dispute with the doctor or office the undersigned agrees that such dispute, if unresolved, will be referred to arbitration, according to Title 3, Sections 36 310 et seq. of the Remedial Code, Oregon Rules of Civil Procedure, before a neutral arbitrator selected by the parties or appointed by the court. Arbitration shall occur in Lane County, Oregon, and may be compelled by petition of either party to the court and any award resulting from such arbitration shall become binding on the parties, upon confirmation by the court. This arbitration clause shall not prevent the doctor or office from taking any action in any court to recover reasonable attorney fees from the adverse party.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient: _____ Date: _____
Print Patient's Name: _____ Date: _____

Signature of Patient's Representative/Guardian: _____ Relationship: _____
Print Name of Patient's Representative/Guardian: _____ Date: _____