Elswick Chiropractic & Associates

Multiple therapies for fast, long-lasting pain relief

Clayton C. Elswick, DC
DC: *cum laude*, Palmer College of Chiropractic, Davenport, IA; BS: Eastern Kentucky University, Richmond, KY; Member: American Chiropractic Association (ACA), International Chiropractic Association, Kentucky Chiropractic Association, ACA Council on Diagnostic Imaging; Certificate of Proficiency: Spinal & Skeletal Radiology; Continuing Education: Musculoskeletal System, Spine; First Team All-American: Baseball, All-South Region,1986.

Frank C. Noble, DC,CCEP
Licensed Doctor of Chiropractic DC: Life University College of Chiropractic, Marietta, GA; Member: American Chiropractic Association (ACA), Kentucky Chiropractic Society, Certified Chiropractic Extremity Practitioner, Certificate of Proficiency: Chiropractic X-Ray Theory and Practice; Continuing Education: Musculoskeletal System, Spine, Extremities; Marathon Runner, Member of Team 413

Effective therapy and lasting pain relief for:

- Lower back pain
- Neck pain
- Headaches
- Migraines
- Nerve pain
- Arthritis pain
- Carpal tunnel syndrome
- Ankle pain
- Knee pain
- Leg pain
- Sports injuries
- Hip pain
- Shoulder pain

With convenience and affordability:

- Most insurance accepted & filed
- Saturdays, morning, evening appts.
- MasterCard & Visa
- Walk-ins welcome
- Payment plans

Multiple therapies in one location:

- Spinal exercise
- Massage therapy
- Rehabilitation
- Physical therapy
- On-site X-ray
- Advanced spinal imaging

3198 Custer Drive, Suite 200
(Close to Man O'War,
Alumni Dr. and New Circle Rd.)
Lexington, KY 40517
(859) 273-8111
(859) 271-3078 Fax

DISCLOSURE & CONSENT
CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustment and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

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 (or for the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors for Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I have been informed and understand that in the practice of chiropractic there are some risks associated with the exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, increased symptoms and pain, and/or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure that the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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.

Patient's Name (please print): ____

Signature of patient/representative: ____________________________________

Doctor's Signature: ______________________________

Date: ____