



instridechiropractic@gmail.com

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In stride CHIROPRACTIC

I am requesting authorization for the following animal(s) to undergo exam and treatment:

Name: _____ Age/breed/weight: _____
Name: _____ Age/breed/weight: _____
Name: _____ Age/breed/weight: _____

I am of lawful age, do understand, authorize, and can substantiate the following:

1. Kaitlyn Lackey is a Doctor of Chiropractic licensed in human care. She has completed postgraduate work in order to become certified by the American Veterinary Chiropractic Association in order to practice animal musculoskeletal manipulation (AMSM).
2. Kaitlyn Lackey is NOT a veterinarian and does not intend to replace traditional veterinary care or take responsibility for my animal's primary healthcare needs. I am seeking AMSM for my animal(s) as a complementary therapy to be used concurrently and in conjunction to my current veterinary care.
3. Texas Law states: "Animal Chiropractic and other forms of musculoskeletal manipulation are systems of therapeutic application of mechanical forces applied manually through the hands or any mechanical device to diagnose, treat and or alleviate impaired or altered function of related components of the musculoskeletal system of non-human animals. Chiropractic...[is] considered to be [an] alternate therap[y] in the practice of veterinary medicine." **22 Tex Admin Code § 573.14.** AMSM does NOT include: dispensing/injecting medication, performing surgery, recommending supplements, or providing any traditional veterinary care.
4. Texas law states: "Alternate therapies, including ultrasound diagnosis and therapy, magnetic field therapy, holistic medicine, homeopathy, chiropractic treatment, acupuncture, and laser therapy, are performed only by a veterinarian or under the supervision of a veterinarian" **Sec. 801.151** It is therefore recommended, that in states where the practice act permits, a chiropractor educated in AMSM perform all services with REFERRAL from a licensed veterinarian providing concurrent care.
5. Kaitlyn Lackey has explained her scope of practice and the procedures to be performed. She has explained risks and benefits of treatment to my satisfaction. I understand that there is no guarantee to the nature of my animal's condition or the resulting outcomes of treatment. I understand that negative reactions to treatment can occur. Though these risks are remote, I know they could happen to my animal if they have pre-existing/underlying conditions. I will indemnify and hold harmless Kaitlyn Lackey and my treating veterinarian should these reactions occur.
6. I allow my veterinarian to share any and all records with Kaitlyn Lackey so she can better understand the nature of my animal's condition.
7. Kaitlyn Lackey has made me aware of her fee schedule. I agree to pay at the time of service for services rendered and for travel costs accrued. I do understand that cancellation fees may be charged if I do not cancel within 24-hour notice of my appointment. I do understand Kaitlyn Lackey can deny future services if I have a credit on my account.
8. Kaitlyn Lackey has made me aware she carries her own liability insurance and is qualified by the AVCA (#1236) and holds current chiropractic license in TX (#13520)

I (animal owner) hereby authorize Kaitlyn Lackey to examine and treat my animal(s) with musculoskeletal manipulation. I certify my animal has had routine and current veterinary care and that I have been open and honest as to any and all other examinations, diagnoses, and treatments for my animal's condition.

Signature: _____ Date: _____

Address: _____

Phone: _____ Email: _____

How did you hear about us? _____

Do we have permission to post pictures/video of your animal on social media? ____Y ____N

(FOR VETERINARIAN TO COMPLETE)

I _____ (referring vet), in compliance with **Rule 573.14**, have performed the following:

1. Established a valid veterinarian/client/patient relationship.
2. Examined the animal(s) to determine that AMSM is not contraindicated.
3. Obtained a signed acknowledgement by the patient's owner (see above) that AMSM is considered under state law to be an alternative and nonstandard therapy.

Signature: _____ Date: _____

Print name: _____

Address: _____

Email (required): _____

Phone: _____ Fax: _____

Would you like to be listed on our website as a preferred referral provider? ____ Yes ____ No