INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Health & Wellness Chiropractic

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor. Some types of manipulation of the neck may be associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. The most current research on the topic is inconclusive as to a specific incident of this complication occurring it is extremely rare. Unfortunately, there is no recognized screening procedure that is 100% accurate in identifying patients with neck pain who are at risk of arterial stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

I acknowledge that I have read and understand the “notice if Privacy Practices for Protected Health Information” and I am entitled to a copy of said information upon my request

Sign only after you understand and agree to the above.

_____

Printed name of Patient

_____ _____

Signature of Patient/ Signature of Representative *Date*

(if patient is a minor or is handicapped)