PERFORMANCE
Health Chiropractic

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INFORMED CONSENT FOR MEDICAL/CHIROPRACTIC EVALUATION AND TREATMENT

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.

Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 to 1 per 10 million treatments. The most recent studies (Journal of the CCA, Vol. 37, No. 2, June, 1993) estimate that incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care.

While it is not generally dangerous, please advise your doctor of chiropractic if you experience soreness or discomfort. Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury. Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment testing and evaluation are performed carefully to minimize risk. Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your doctor of chiropractic or staff if they occur. There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor of chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your doctor of chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

I hereby request and consent to the performance of any medical and/or Chiropractic procedures including examination, diagnostic X-rays, and various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the doctor or doctors and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor(s), including those working at this clinic or any other office or clinic.

I have had an opportunity to discuss with the doctor of Chiropractic and/or with other clinic personnel of the office, the nature and purpose of Chiropractic adjustments and other procedures.

I understand and am informed that, in the practice of medicines or Chiropractic there are some risks to treatment including, but not limited to: fracture disc injuries, strokes, dislocations, and sprains. 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, which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read or have had read to me, the above consent. I have also had the 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 the treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's name: _____ Signature of Patient: _____

Date signed: _____ Witness of Patient's Signature: _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Representative name: _____ Date signed: _____

Signature of representative: _____ Relationship or authority of patient's representative: _____