Informed Consent to Chiropractic Treatment

Advanced CHIROPRACTIC

1117 Pacific Blvd. SE ~ Albany, OR ~ Ph: 541-928-1010 Fax: 541-928-1093

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent when starting treatment.

I _____, of _____ do
(Patients Name) (Town of Residence)
hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. These manipulations/adjustments may be **performed by any of the chiropractors on staff** at this office. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

_____ INITIALS Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

_____ INITIALS Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other
_____ INITIALS abnormality is detected, this office will proceed with extra caution. If a tendon is weak or partially torn, manipulation may cause it to tear the rest of the way.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am
_____ aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.
INITIALS Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite pre-
_____ cautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to
INITIALS the doctor.

Tests have been performed on me to minimize the risk of any complications from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing including
_____ other chiropractors that work for this office and certified assistants.
INITIALS

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

_____ Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of
INITIALS medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesired side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

_____ Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may tempo-
INITIALS rarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

_____ Surgery: Surgery may be necessary for joint instability or serious disk rupture. Surgical risks may include unsuc-
INITIALS cessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

_____ Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/
INITIALS adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ _____

Signature of patient Signature of guardian

_____ Signature of witness _____ Date

Condition of Patient at Time of Consent Process

Based on my personal observation and direct conversation with the patient, I conclude that throughout the consent process he/she was:

[ ] Of legal age
[ ] Under the age of 18. The legal guardian of the patient has given consent to the Treatment of this youth.
Guardian Name: _____
[ ] On prescription/OTC medication but unimpaired.
[ ] Resolute in denying the use of alcohol and/or recreational drugs prior to consent.
[ ] Oriented as to time and place.
[ ] Coherent and lucid.
[ ] Able to understand the language used.
[ ] Assisted in understanding by use of an interpreter.
Interpreter's name: _____
[ ] Assisted in consent process by family members:
Name: _____ Relationship: _____
[ ] Assisted in consent process by staff member.
Name: _____ Relationship: _____
[ ] I encouraged and answered questions regarding this form with the patient.
[ ] PARQ films:
_____

Patient had the following questions and was supplied with the following answers:

Comments: _____

_____

I certify that the above accurately described the consent process in this case.

_____ _____

Date Signature of Doctor

Kevin M. Ross, DC Kristen M. Livingston, DC

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Kristen M. Livingston, DC

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Acknowledgement of Receipt of
Notice of Privacy Practices

NOTICE TO PATIENT

This form will be retained in your medical record.

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Advanced Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by Advanced Chiropractic and informs me of my rights with respect to my protected health information. I also understand that I can find this entire form on www.AdvancedChiroClinic.com website.

_____ _____

Patient's Signature *or that of Legal Representative* ***Printed Name of Patient*** *or that of Legal Representative*

_____ _____

Today's Date ***If Legal Representative, Indicate Relationship***

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____ _____

Employee's Name **Today's Date**