

Informed Consent to Treat

TO THE PATIENT: Please read this entire document prior to signing it. You have a right to be informed about your condition, the recommended chiropractic treatment and the potential risks involved with the recommended treatment. It is important that you understand the information contained in this document. Please ask questions before signing, if there is a topic that you do not understand and we will be pleased to explain it.

Analysis/Examination Treatment

As a part of the analysis, examination and treatment of your condition, you are consenting to the following procedures:

- | | | |
|-------------------------|-----------------------------|------------------------------|
| -Palpation | -Active Rehab | -Mechanical Traction Therapy |
| -Orthopedic Testing | -Vital Sign Testing | -Range of Motion Testing |
| -Radiographic Studies | -Basic Neurological Testing | -Muscle Strength Testing |
| -Electrical Stimulation | -Hot/Cold Therapy | -Spinal Manipulative Therapy |
| -Ultrasound Therapy | -Soft Tissue Therapy | -Massage |

The Nature of the Chiropractic Adjustment

The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. The Doctor of Chiropractic named below may perform the chiropractic treatment and/ or other licensed Doctors of Chiropractic working at this clinic or office. A chiropractic treatment may consist of the Doctor of Chiropractic using a mechanical instrument or his/her hands upon your body in such a way as to produce movement of your joints. This may cause an audible "pop" or "click" similar to when you "crack" your knuckles and you may feel a sense of movement.

The Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications, which may arise during chiropractic treatment and therapy. These complications include, but are not limited to fracture (broken bones), dislocations, muscle strains, costovertebral strains and/or separations, intervertebral disc injury, cervical myelopathy and bums. Some patients may experience stiffness and/or soreness following the first few days of treatment. Certain types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including arterial dissection (stroke). 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 him/her.

The Probability of Those Risks Occurring

Fractures are a rare occurrence and generally result from some underlying weakness of the bone, which we check for during history taking, examination and radiographic studies (x-ray). Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all, it is extremely rare and remote. Unfortunately, there is no recognizing screening procedure to identify patients with neck pain who are at risk of arterial stroke.

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Other Treatment Options:

Other treatment options for your condition may include:

- Rest and over-the-counter medications (analgesics, etc.)
- Medical care including prescription medications (pain-relievers, muscle relaxants and/or anti-inflammatory medications, etc.)
- Physical Therapy
- Hospitalization
- Surgery

If you choose to use one of the above "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician before proceeding.

The Risks to Remaining Untreated

Remaining untreated may allow for the formation of adhesions and reduced joint mobility, potentially setting up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer treatment has been postpone.

CONSENT TO TREAT (MINOR)

I hereby request and authorize Jasmine S. Scott, D.C. and associates to perform diagnostic tests and render chiropractic treatment and/or other treatment to my minor son/daughter:

_____. This authorization also extends to all other doctors and office staff members and is intend to include radiographic studies at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

I have read [] or have had read to me [] the above information regarding chiropractic adjustments and related treatment. I have discussed it *with* either Jasmine S. Scott, D.C. or one of *her* associates and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the recommended treatment. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name: _____ Doctor's Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Name of Parent or Guardian (if a minor): _____

Signature of Parent or Guardian (if a minor): _____