Consent to treat in the office of Positively Chiropractic

Informed Consent – Chiropractic, Manual Therapy, Acupuncture, Nutrition

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Patient's Name: _____

Instructions: This document relates to your Informed Consent for care.

Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document in their entirety and understand the potential benefits and risks of the Care provided to me. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that this form covers anyone listed above as a provider though I may not seek treatment from each individual provider, at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating to diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some 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 stroke and death. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge. I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery. I do not expect the clinical staff to be able

to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, and is in my best interest. I understand that results are not guaranteed.

Acupuncture: I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile DISPOSABLE needles and maintains a clean and safe environment.

Cupping: This therapy utilizes silicone or plastic cups and a vacuum pistol to create suction on the body surface. These cups are moved over the skin using gliding, shaking, popping and rotating techniques while gently pulling up on the cup, or may be parked for a short time to facilitate joint mobilization or soft tissue release. Suction reaches deep into the soft tissue, attachments and organs. Potential reactions, discoloration due to toxins and old blood being brought to the surface, post tenderness, decreased blood pressure, redness, blisters and itching.

Massage: I understand and am informed that in the practice of massage therapy there are some risks to treatment including but not limited to, delayed musculoskeletal soreness, bruising, inflammation, pain, decreased range of motion, changes in blood pressure, and the exacerbation of symptoms related to afore-treated condition. In extremely rare cases, there may be a risk of heart attack, stroke, pulmonary embolism, or thrombosis. I acknowledge and understand that the massage therapist must be fully aware of my existing medical conditions. I have disclosed to the massage therapist all of those medical conditions affecting me. For some medical situations, massage may be contraindicated. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge. Pain and soreness may occur after treatment.

ALL PROVIDERS WHO WORK IN THIS OFFICE ARE INDEPENDENT CONTRACTORS.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all services provided at said location, as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Name: _____

Patient's Signature: _____

Date of Signature: ___/___/___

Name of Parent / Guardian / Authorized Representative: _____

Signature: _____ Date of Signature: ___/___/___