Consent

Patient Name:_____

# Consent to Chiropractic Treatment

There are some inherent risks that may be associated with chiropractic or acupuncture treatment, but not limited to:

- While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
- There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- There have been reported cases of injury to a vascular structure following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.
- I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I acknowledge I will have the opportunity to discuss the following with my healthcare provider:

a) The condition that the treatment is to address;
b) The nature of the treatment;
c) The risks and benefits of the treatment;
d) Any Alternatives to that treatment.

I will have the opportunity to ask questions and receive answers regarding the treatment.

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 appreciated there is no certainty that I will achieve these benefits. I realized that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding that outcome of these procedures.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation.

Patient Name: _____
Print Name Signature Date

- OR -

Patient Representative or Guardian: _____
Print Name & Relationship to Patient Signature Date