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CONSENT FOR TREATMENT

PATIENT NAME ______________________________

To the Patient:

Please read this entire document before signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way to move your joints. This may cause an audible "pop" or "click", as you may have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis, Examination, Treatment:

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

✓ spinal manipulative therapy	✓ radiographic studies	✓ hot/cold therapy
✓ range of motion testing	✓ palpation	✓ vital signs
✓ muscle strength testing	✓ orthopedic testing	✓ basic neurological testing
✓ ultrasound	✓ postural analysis	✓ EMS

____ Other

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The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

CONSENT FOR TREATMENT (continued)

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for when taking your history, x-rays and performing your examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self administered, over-the-counter analgesics and rest.
- Medical care and perscription drugs such as anti-inflammatory, muscle relaxants and pain killers.
- Hospitalization
- Surgery

If you choose to use one of the above noted "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.

The risks and dangers attendant in remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read ☐ or **have had read to me** ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed treatment concerns with Brett M. Herrington, D.C. and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I have been informed of the risks.

I hereby give my consent to that treatment.

______________________	______________________
DATE	**DATE**
______________________	______________________
PATIENT NAME (please print)	**DOCTOR NAME (please print)**
______________________	______________________
PATIENT SIGNATURE	**DOCTOR SIGNATURE**
______________________	
SIGNATURE of PARENT or GUARDIAN (if a minor)	