

Informed Consent for Chiropractic Care

Patient Name*

Email*

Phone*

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care.

The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors.

Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in progress.

However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Prior to receiving chiropractic care in this Chiropractic office, health history and physical exam will be completed. These procedures are performed to assess your specific condition, your overall health, and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment.

In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

The risks and dangers attendant to 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 INITIAL THE APPROPRIATE BOX BELOW.

I have read [] or have had read to me [] and understand the above explanation of the chiropractic adjustment and related treatment. I have had the opportunity to discuss this and have no questions at this time. 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. Having been informed of the risks, I hereby give my consent to that treatment.

Select

I have read

Have had read to me

Date

Patient Name

Patient Signature

Signature of Parent or Guardian (if minor)

Date

Doctor's Name

Doctor's Signature

Consent to Treat, Privacy and Billing Practices Notice

By signing this form, **you are consenting to an examination**, if applicable, at Wang Chiropractic Inc. We employ standard examination methods including, but not limited to, the following:

- *Observation*: General assessment/appraisal in all positions
- *Inspection*: Viewing/looking at your body parts. Visualization includes general body viewing in a standing position, front, back and side. All symptomatic (painful) body parts may be viewed. Women may continue wearing a bra in the course of examination unless it obscures visualization/viewing of injured/abnormal body parts. Women may request a female observer be present at any time.
- *Auscultation*: Using stethoscope to listen for blood pressure and other body sounds.
- *Palpitation*: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity of tissues, integrity, and abnormality.
- *Percussion*: Using rubber hammer and tapping on bones or tendons.
- *Orthopedic/Neurological Testing*: These are standard tests to assess your neuromuscular-skeletal systems .

NOTE You do not have to submit to any examination procedure. We ask that you comply to the best of your ability and report changes in your pain. All procedures are accomplished at your tolerance.

I provide **consent to undergo treatment** under the care of *Wang Chiropractic Inc.* I hereby request and consent to treatment procedures, including, but not limited to, various modes of physical therapy, manipulation, and massage on me (or on the patient named below, for whom I am legally responsible) by the staff of *Wang Chiropractic Inc.*, including those working at this clinic or office or any other office or clinic.

PRIVACY - Your privacy is very important to us and we will do everything we can to protect it. We abide very strictly to all HIPPA Regulations. Some treatments are performed in public spaces, with only partial privacy, with other patients and staff members present.

We find that open treatment spaces improve care by facilitating interaction between people suffering from similar conditions. We realize that this provides a forum between patients to discuss additional healing, treatment, and management strategies and empowers patients. You may at any time refuse treatments or ask for a private space for treatments. If a treatment cannot be performed

in privacy, you may refuse to undergo treatment and reschedule without assessing a late cancellation fee.

BILLING PRACTICES - Our billing practices and line item charges are in complete alignment with the rules and regulations set forth by each individual insurance company as being reasonable and customary for the area of practice. We offer to verify private insurances at no charge; however, this is not guarantee of payment.

We make every effort to explain all aspects of insurance coverage during the intake process; however, upon receiving an Explanation of Benefits from the insurance company, if there are any questions, I understand that I have the right to address them directly with the billing manager.

By signing below, I am stating that I understand the above statement and agree to submit to the above procedure/s and accept the risks and consequences of their application. I hereby declare that all the information I have submitted in this entrance paperwork is accurate and complete. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions/s for which I seek treatment at *Wang Chiropractic Inc.*

Print Patient Name

Signature of Patient (or Legal Representative if under 18 years of age)

Name of Legal Representative (if applicable)

Date