CAPITAL CHIROPRACTIC CENTER, P.C.

**INFORMED CONSENT**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To the patient**: Please read this entire document prior to 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 we use as Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

**Analysis / Examination / Treatment**

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

~ spinal manipulative therapy

~ palpation

~ vital signs

~ range of motion testing

~ orthopedic testing

~ basic neurological testing

~ muscle strength testing

~ postural analysis

~ ultrasound

~ hot/cold therapy

~ EMS

~ radiographic studies

~ Other (please explain)

**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 or aggravation of disc conditions, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. This office treats patients with disc injuries or conditions, many of whom experience significant relief. There are cases where no relief is provided, or aggravation of the condition occurs. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history, during examination, and X-ray if indicated. 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. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. We 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 our attention, it is your responsibility to inform us.

**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 prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers

• Hospitalization

• Surgery

If you chose 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.

**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. If I have any questions regarding anything on this form including treatment, risks associated with treatment, or other treatment options, I will discuss it with the Chiropractic Physicians at Capital Chiropractic Center, P.C. 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.**

**Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Patient’s Name Doctor’s Name**

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**Signature Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent or Guardian**

**Consent for Treatment:**

***Assignment & Release*** *- By signing below, I authorize* ***Capital Chiropractic Center, P.C.*** *to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to* ***Capital Chiropractic Center. P.C.*** *and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

***Cancellation Policy*** *- It is the policy of this clinic to require 24 hours advance notice for all appointment cancellations to allow the physicians maximum availability for their patients. To ensure availability is managed appropriately, it is necessary for us to have the following policy for missed appointments: Missed appointment fees for standard Chiropractic office visits will be charged at $25.00. Missed appointment fees for Re-exams, Physicals, X-rays, or Procedures will be charged at $50.00 as considerable time is set aside for these visits. This charge is not covered by insurance and will be the patient’s responsibility. The patient may also be dismissed from the practice due to excessive missed appointments. New patients who miss a second scheduled appointment will not be permitted to schedule future appointments or be accepted into the practice by any other physician.*

*By signing below, I give my consent for examination, the performance any necessary tests or procedures, and treatment. I acknowledge and agree to the terms set forth in this agreement. If patient is a minor, by signing I give consent for examination, the performance of tests or procedures, and treatment for the above minor patient.*

Signed: Date: