Brent
Family Chiropractic

**PATIENT NAME:_____**

**CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT**

**ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY**

**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.

**INFORMATION ABOUT CHIROPRACTIC MANIPULATION**

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT **PATIENT INITIALS_____**

The primary treatment used at Brent Family Chiropractic, PLLC, is spinal manipulative therapy. It is likely that spinal manipulative therapy will be used as part of your treatment. Spinal manipulative therapy includes use of the doctor's hands and mechanical instruments upon your body in such a way to mobilize your joints. This movement may cause an audible "pop" or "click," such as experienced when you "crack" your knuckles. You may also feel a sense of movement.

THE MATERIAL AND INHERENT RISKS IN CHIROPRACTIC ADJUSTMENT **PATIENT INITIALS_____**

All patient care, including chiropractic treatment, has the potential for negative side effects. The risks associated with chiropractic treatments include, but are not limited to, strains and sprains, dislocations, disc injuries, fractures, and strokes. These negative effects are very rare and will be explained to you after the examination has been completed and a treatment plan had been developed specific to your needs.

THE PROBABILITY OF THOSE RISKS OCCURRING **PATIENT INITIALS_____**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor looks for during your initial consultation, examination, and while reviewing your x-rays. The incidence of a stroke is exceedingly rare and is estimated to occur between one in one million and one in five million adjustments of the neck. 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: **PATIENT INITIALS_____**

- Self-administered, over-the-counter analgesics and rest
- Medical care & prescription drugs such as anti-inflammatory, muscle relaxants, or painkillers
- Physiotherapy
- 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 want to discuss these with your primary care physician.

**THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED** **PATIENT INITIALS_____**

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

**FINANCIAL RESPONSIBILITY-PAYMENT AND INSURANCE** **PATIENT INITIALS_____**

I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and me. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are my personal responsibility. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable**. I understand I am responsible for a $25 fee for no show or late cancellation** (less than one hour).

**THE EXAMINATION** **PATIENT INITIALS_____**

Prior to establishing a treatment plan the doctor must perform an examination in order to determine the exact cause of your complaint. During this examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of the nature of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

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

I have read [ ] or have had read to me [ ] the above explanations of the Brent Family Chiropractic, PLLC, operations and the nature of chiropractic examination and treatment.

By signing below I state that I consent to a chiropractic examination and to the chiropractic treatments offered or recommended to me (*or the patient listed below to whom I am the legal guardian*) by my doctor, including spinal adjustments. Once a treatment plan is established I will have the opportunity to discuss the treatment plan with my doctor and to consent to the proposed care.

_____ _____

PATIENT NAME (PRINTED) WITNESS NAME (PRINTED)

_____ _____

PATIENT NAME (SIGNED) OR LEGAL GUARDIAN WITNESS NAME (SIGNED)

_____ _____

DATE DATE