# *Informed Consent To Chiropractic Treatment*

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

**Possible risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

**Other treatment options** that could be considered may include the following:

- *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

| Printed name | Signature | Date |
|---|---|---|

# McCauley Chiropractic Center
## CONSENT FORMS

We are very concerned with protecting your privacy. While the law requires us to give you a copy of your *Patient Bill of Right*, please understand that we have, and always will, respect the privacy of your health information.

**A. Consent for Use or Disclosure of Health Information**

By signing, you agree and understand how this office uses your protected health information (PHI) as stated in your *Patient Bill of Rights for Protected Health Information,* **and give consent to operate under those protocols as outlined.**

NOTE: **1**. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you upon your next visit. **2**.You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing and do not sign this consent. **3**.You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we have received your request to revoke your authorization.

I have read this Protected Health Information (PHI) consent form and understand my rights to change/revoke this consent at any time.

_____

**Signature** **Date**

**B. Consent for Correspondence**

This office uses telephone and mail for correspondence. Telephone calls are made if an appointment has been missed, needs to be re-scheduled, or as a reminder. Voice mail and answering machine messages will be left if available, leaving the minimum amount of information possible for you to return the call. Mail is used for non-clinical office update information, birthday cards, health newsletters.We do send copies of our examination findings to your primary care physician as a courtesy to you.

NOTE: **1**. You have the right to request that we do not use any or all forms of correspondence. If you would like to place any restrictions on correspondence, please let us know in writing and do not sign this authorization. **2**. You have the right to revoke this authorization at any time; however, your revocation must be in writing.

I have read this correspondence authorization form, give authorization to contact me by any of these methods, and understand my rights to change/revoke this authorization at any time

_____

**Signature** **Date**