

# CONSENT TO CHIROPRACTIC TREATMENT PLAN

## THE MATERIAL RISKS INHERENT TO YOUR TREATMENT

Chiropractic care is a safe and effective approach for many health conditions, however as with any health care procedures, chiropractic treatments present the risk of complications or negative side effects. The list below includes the various treatments available in our office and the most common potential risks associated with these treatments.

## **CHIROPRACTIC MANIPULATION THERAPY/MYOFACIAL RELEASE/STRETCHING/NEUROMUSCULAR EDUCATION/EXERCISE**

The risks associated with chiropractic treatments included, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and your doctor has done a careful screening for contraindications during the consultation and examination. Another more common side effect associated with chiropractic manipulation and therapy is some soreness or stiffness following the treatment. We may recommend the use of ice packs to reduce the discomfort. Symptoms may, however, increase initially.

## **HOT / COLD THERAPY/Ultrasound/Electrotherapy/Rock Tape/Kinesio Tape**

Applications of the above can cause a local burn or rash. Please inform the doctor if the application or treatment is painful, stinging, burning or uncomfortable.

## **ALTERNATIVE TREATMENT OPTIONS**

There may be other ways to treat your case. These include but are not limited to: doing nothing, medicines, surgery, other forms of complimentary treatment, and seeking a second opinion. We do not recommend any medications, we will refer you if necessary or if you should consult with your medical provider. All have risks involved and may be discussed with your doctor if you should choose. **\*\*\*Please inform the staff if you are pregnant\*\*\***

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

I have read or had read to me the above explanation of chiropractic adjustments and related treatment. I have discussed it with either Drs. Hutti if I have had any concerns.

By signing below I state I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest (or, in the case of a minor, in the best interest of the patient) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to the treatment.

This office conforms to the current HIPPA guidelines. You may request a copy of our current HIPAA policy on file at the front desk. Please initial to indicate you have been made aware of its availability.

\_\_\_\_\_ (Initials)

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

\_\_\_\_\_ Patient's name

\_\_\_\_\_ Patient's or Parent/Guardian's signature