CHIROPRACTIC CARE

Chiropractic care is a system that, in theory, uses the recuperative powers of the body and the relationship between the musculoskeletal structure and functions of the body in the restoration and maintenance of health. The treatment involves "hands-on" joint manipulation.

Patient's
Initials

____ The details of the treatment including the anticipated benefits and material risks have been explained to me in terms I understand.

____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

____ I understand and accept that the most likely material risks and complications of chiropractic care have been discussed with me and may include but are not limited to:

- *fatigue following manipulation*
- *headache*
- *radiating discomfort*
- *treatment unsuccessful in its intended purpose/no relief*
- *worsening of condition being treated*

____ I understand and accept the less common complication of stroke following manipulation of the neck.

____ I have informed the doctor of all previous operations, including but not limited to, spinal fusion and acute fractures and dislocations.

____ I have informed the doctor of my past medical history, including but not limited to history of hypertension and/or cardiac conditions.

____ I have informed the doctor whether I have musculoskeletal problems, such as osteoporosis, bone or joint infections, bone cancer, acute rheumatoid arthritis, and/or disease of the spinal cord or bone marrow.

____ I am aware and accept that no guarantees about the results of the treatment have been made.

____ I have been informed of what to expect post treatment, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional treatments.

____ The doctor has answered all of my questions regarding this treatment.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ____________________________, D.C., with associates or assistants of his or her choice, to perform the following procedure of ____
(joint[s])

manipulation on ____at_________________________.
(patient name) *(Facility name)*

It is anticipated that this treatment will need to be repeated ________ day(s) per week for _______ week(s).

____
Patient or Legal Representative Signature/Date/Time

____
Relationship to Patient

____
Print Patient or Legal Representative Name

____
Witness Signature/Date/Time

6/02
Revised 9/05, 12/05, 1/06, 3/08

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).

SAMPLE

Continued

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the ***patient/legal representative*** *(circle one)* fully understands what I have explained.

____
Chiropractors Signature/Date/Time

_______ copy given to patient
initial

_______ original placed in chart
initial

SAMPLE

6/02
Revised 9/05, 12/05, 1/06, 3/08

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).