Dowsett Chiropractic Health Center
Dr. Timothy J. Dowsett
301 Commercial St.
Dowagiac, MI 49047 (269) 782-3247

Informed Consent Document

Patient Name ____

To the Patient: Please read the 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 I use as Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I will use my hands 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" you knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to any one or all of the procedures:
Check any procedure to which you DO NOT grant your consent:

___ spinal manipulative therapy	___ palpation	___vital signs
___ range of motion testing	___ orthopedic testing	___basic neurological
___ muscle strength testing	___ postural analysis testing	
___ ultrasound	___ hot/cold therapy	___ EMS
___ radiographic studies	___ massage therapy	___ other

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, dislocation, muscle strain, cervical myelopathy, costovertebral strains and seperations and burns. Some types of manipulation of the neck have been associated with the injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform me.

The probability of those risk occurring.

Fracture are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject or tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in a million and one in five million cervical adjustments. 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:
*Self administered, over the counter analgesics and rest *Medical care and prescription drugs such as anti-inflammatory, muscle relaxant 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 risk and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and danger attendant to remaining untreated.

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

Do not sign until you have read and understand the above.

I have read or had discussed the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Timothy J. Dowsett, D.C. and have had any questions answered to my satisfaction. 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. Have been informed of the risks, I hereby give my consent to that treatment.

Date:____________________ Patients Name:____________________________ Signature:____________________________

Signature of Parent of Guardian____________________________ Doctor Signature:______________________________
(if a minor)

Consent for Purposes of Display

I acknowledge that Dowsett Chiropractic Health Center may post my name in their waiting room for reasons of patient referrals, birthdays, winnings, congratulations, and thank yous.

I understand in signing this authorization that Dowsett Chiropractic Health Center has my permission to post my name for any reasons listed above at any time without notification to me. I understand that Dowsett Chiropractic Health Center is posting my name for only reasons of appreciation for being part of their chiropractic family.

______________________________ ______________

Signature of Patient or Personal Representative Date

______________________________ / ______________

Name of Patient or Personal Representative Relationship

☐ Refuse Request

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that **Dowsett Chiropractic Health Center's** "Notice of Privacy Practices" has been provided to me, as it is posted in front of the office at all times.

I understand I have a right to review **Dowsett Chiropractic Health Center's** Notice of Privacy Practices prior to signing this document. **Dowsett Chiropractic Health Center's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Dowsett Chiropractic Health Center**. The Notice of Privacy Practices for **Dowsett Chiropractic Health Center** is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and **Dowsett Chiropractic Health Center's** duties with respect to my protected health information.

Dowsett Chiropractic Health Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________ ______________

Signature of Patient or Personal Representative Date

______________________________ / ______________

Name of Patient or Personal Representative Relationship

____

Description of Personal Representative's Authority

☐ Refuse to Sign, would like a copy to take home and review

☐ Refuse to Sign