DUBLIN FAMILY Chiropractic

Informed Consent Document

The purpose of this form is to inform you about the nature, risks, and benefits of chiropractic evaluation and treatment, and to obtain your informed consent before beginning care.

THE NATURE OF CHIROPRACTIC CARE

Chiropractic care involves the evaluation, diagnosis, and treatment of patients using procedures such as spinal and extremity adjustments or manipulations, mobilization, soft tissue techniques, exercise therapy and lifestyle counseling. Chiropractic care is non-surgical and drug-free.

POTENTIAL RISKS

As with any healthcare procedure, there are potential risks associated with chiropractic treatment. These include, but are not limited to:

- Temporary soreness, stiffness, or increased pain
- Sprains/strains
- Dizziness, nausea, or headaches
- Cervical myelopathy or radiculopathy
- Fractures, dislocations, costovertebral (rib articulation) strains and separations
- Rare but serious complications such as disc injury, nerve injury, stroke, or vertebral artery dissection (estimated incidence: 1 in 1-5 million cervical manipulations) *Unfortunately there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

Many patients feel generally mild symptoms such as soreness and stiffness following the first few days of treatment. The Doctor 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 the Doctor's attention, it is your responsibility to inform the Doctor.

POTENTIAL BENEFITS

Chiropractic care has been shown to help reduce pain, improve function, and enhance overall health and well-being. It may assist with conditions such as back and neck pain, headaches, joint problems, and musculoskeletal injuries.

ALTERNATIVE TREATMENTS

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Hospitalization/Surgery
- Physical therapy
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxers and steroids or pain-killers

If you chose to use one of the above listed “alternative treatments” options, you should be aware that there are still risks and benefits of such options and you may wish to discuss these with your primary medical care provider.

Remaining untreated may allow the formation of adhesions (scar tissue) 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.

CONSENT TO TREAT (MINOR)

I hereby request and authorize Dr. Jamie L. Berringer to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization extends to all other doctors and staff members.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

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

I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatment. I hereby request and consent to chiropractic care and treatment provided by the chiropractor(s) at this clinic. I understand that I may withdraw my consent and discontinue treatment at any time.

- I have had the opportunity to discuss the nature and purpose of chiropractic care.
- I understand the potential risks and benefits involved in receiving chiropractic treatment.
- I have had all of my questions answered to my satisfaction.

By signing below, I acknowledge that I have read and understood this consent form.

Patient Signature: _____ Date: _____

If patient is a minor Parent/Guardian Signature

_____ Date: _____

Doctor’s Name: Dr. Jamie L. Berringer, DC, CCSP Signature: Dr. Jamie L. Berringer, DC, CCSP