Miracles Health Care Center

TOTAL BODY RELEASE CHIROPRACTIC CARE

Dr. Mari E. Schwartz, D.C.

Informed Consent to Chiropractic Treatment

Doctors of Chiropractic are required by law to obtain your informed consent before starting treatment procedures.

I, _____, do hereby give my consent to the performance of conservative noninvasive treatment of the spine, joints of the body, and related soft tissues. I understand that the procedures may consist of adjustments/manipulations involving the movement of the joints and related soft tissues. Physical therapy and exercises may also be used.

Although spinal adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Stiffness: I am aware that it is reasonable to expect and experience some degree of muscle soreness/stiffness in the first few treatments. I am also aware that the possibility exists that muscle soreness/stiffness may be experienced following any adjustment.

Dizziness: Temporary symptoms like dizziness and nausea can occur following an adjustment, but do realize that these incidences are relatively rare.

Fractures/ Joint Injury: I further understand that in isolated cases with underlying physical defects, deformities or pathologies, like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes related to chiropractic adjustments are rare.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor immediately.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

ALTERATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, exercises, medications, seeking other professionals for treatment and possible surgery.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

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Medications: It is the policy of this office to not recommend or denounce the use of any prescription or over-the-counter medication. It is my responsibility to be aware of the effects of such medications. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may cover-up pathology, produce only inadequate or short-term relief, have undesirable side-effects, cause physical or psychological dependence, and have to be continued indefinitely. Some medications may involve serious risks.

Surgery: Surgery may be necessary for joint instability or serious disk rupture. Surgical risks may include unsuccessful outcome, complication, increased pain, reactions to anesthesia and prolonged recovery.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with the treatment procedures including, but not limited to, decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainly that I will achieve these benefits.

I realize that the practice of chiropractic is not an exact science and I further acknowledge that no guarantee has been made to me regarding the outcome of procedures.

I agree to the performance of these procedures by my doctor and other such person of the doctor's choosing.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesive tissue formation, restricted motion, nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and legthy.

Missed Treatments: I understand that should I not follow through with the recommended treatment plan, that my recovery time will be lengthened. I further understand that missing treatments may have an adverse effect on my rehabilitation with a resultant return to a pre-treatment health status.

I have read, or have had read to me, the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction, PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for chiropractic treatment.

_____ Signature of Patient

_____ Signature of Witness

_____ Date

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