Consent To Chiropractic Examination & Treatment

As a patient, you are entitled to be informed of the purpose, benefits, and potential risks of a health care procedure and to make the decision about whether or not to undergo the procedure. Please read this entire document before signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The Nature of the Chiropractic Adjustment

Chiropractic providers utilize spinal manipulation as a primary method of treatment. If your provider believes it is indicated in your case, your provider will use this treatment by placing their hands or a mechanical instrument 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” your knuckles. You may feel a sense of movement.

Other Examinations, Tests, and Treatments

In addition, your provider may use other tests and examinations, some of which are listed below, if your provider believes they are warranted based on your condition and the information you provide. As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, assessing vital signs, range of motion testing, physical exam procedures, orthopedic testing, basic neurological evaluation, muscle strength testing, ultrasound, hot/cold therapy, electrical muscle stimulation, radiographic (X-ray) studies, advanced imaging, mechanical traction, blood testing, and specimen testing.

You understand that if you report to your provider that you are pregnant or may be pregnant, your provider will not use X-ray studies on you and will use other techniques, as available, to diagnose your condition to the best of their ability.

Material Risks of Chiropractic Adjustment

As with any healthcare procedure, certain complications may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke. Please ask if you would like additional information regarding cervical spine adjustments and the risk of stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Your provider 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 your provider's attention, it is your responsibility to inform them.

Availability and Nature of Other Treatment Options

Other treatment options for your condition may include medication, injections, and surgery. If you choose to use one of the above-noted “other treatment” options, you should discuss the risks and benefits with your primary medical or osteopathic physician.

Risks of Remaining Untreated

Delays in treatment may cause the formation of adhesions, scar tissue, and other

degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. Therefore, delay of treatment may complicate the condition and make future rehabilitation more difficult.

Discontinuance of Care Against Your Provider's Advice

Patients may choose to discontinue care from this clinic at any time. However, patients who choose to discontinue care before completion of their recommended care plan agree to follow up with their primary care provider or another medical provider immediately. Unresolved complaints can sometimes indicate serious underlying pathology that requires additional care to prevent more serious consequences. Foregoing this advice may lead to progressive problems with serious consequences, including death in rare instances.

Consent to Visit Recording

As part of our documentation process, your provider may use secure audio recording and transcription tools during your visit. These recordings are processed using artificial intelligence to generate a written summary, which becomes part of your official medical record. Audio recordings and raw transcripts are considered transitional tools and may be, but are not necessarily, retained as part of the medical record by default. Your provider may retain a specific recording or transcript if they believe it may be clinically relevant or useful for future reference. In such cases, the retained content may be considered part of the medical record and could be subject to applicable legal and regulatory standards. Access to recordings and transcripts is restricted, view-only, and fully audited. By signing this agreement, you consent to the aforementioned recording and documentation process. If you prefer not to have your visit recorded, you may opt out by submitting a written request to our office. Your care will not be affected if you choose to opt out.

For Parent or Guardian Signing Form on Behalf of Patients Under 18 Years of Age I, being the parent, guardian, or custodian of the minor, do hereby authorize and request this office and its doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that, in their judgment, is deemed advisable or required. I understand that the providers and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as needed while the above-named minor is under care in this office until legal age is attained. I also understand that, as part of the care process, secure audio recordings and AI-generated transcripts may be used as described above. As the legal parent/guardian, I consent to the use of these tools during the minor's visit(s), including the creation and potential retention of audio recordings or transcripts as part of the medical record. I also accept full responsibility for all charges and payments due.

This office observes all laws regarding a minor patient's right to consent to and to the confidentiality of his or her healthcare treatment. In addition, this office follows a policy of transitioning adolescent patients to self-management of their own health. We view our office visits as an opportunity for your child to learn to take responsibility for their health care. Therefore, as appropriate for the age and maturity of the patient, parents may be asked to excuse themselves for a portion of or the entire health care visit. By signing this form, the parent or responsible party acknowledges understanding and consent to this policy.

Authorization

I have read or have had read to me the above explanation of the chiropractic management and related treatment, as outlined in this document. I will discuss any concerns or potential issues with my provider and have my questions answered to my satisfaction before any assessment or treatment is initiated. By signing below, I state that I have weighed the risks and benefits involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I understand that the doctor will use their best professional judgment, but cannot and does not guarantee any outcome or results. Having been informed of the risks by my provider, I hereby consent to treatments and examinations as outlined in this document.