Northwoods Family Chiropractic

202 W Adams Street
Iron River, MI 49935
906-265-9000

328 Superior Avenue
Crystal Falls, MI 49920
906-874-0111

Informed Consent

Medical doctors, chiropractic doctors and osteopaths who perform manipulation are required by law to obtain your informed consent before starting treatment.

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

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

Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fracture/Joint Injury: I further understand that in isolated cases 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 clinic will proceed with caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

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

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

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

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

Alternative Treatments Available

Reasonable alternative to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware tat long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

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 join stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

No treatment: I understand the potential risk of refusing or neglecting care may include increase pain, scar/adhesion, formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology, The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

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 herby affix my signature to this authorization for treatment.

_____ Signature of patient/guardian

_____ Signature of witness

_____ Date and time

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Northwoods Family Chiropractic (Please initial one of the following options and sign below.)

I acknowledge that I have read the Notice of Privacy Practices from Northwoods Family Chiropractic prior to signing this document. Northwoods Family Chiropractic 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 the bills, or the performance of health care operations of Northwoods Family Chiropractic. The Notice of Privacy Practices for Northwoods Family Chiropractic is also provided on request at the main administration desk of the practice. This Notice also describes my rights and Northwoods Family Chiropractic's duties with respect to my health information.

Northwoods Family Chiropractic 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 clinic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

X_____ _____
Signature of Patient/Guardian Date

X_____ _____
Witness (Office Staff) Date