



Informed Consent Document

PATIENT NAME: _____

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

Please read this 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 used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. The doctor may use my 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.

The risks inherent in chiropractic adjustment.

It is important that you understand, as with all health care approaches, results are not guaranteed and there is no promise to cure. As with all types of health care interventions, there are certain complications which 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. 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. Some patients will feel some stiffness and soreness 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.

The availability and nature of other treatment options.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measure and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

The risks and dangers 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.

Consent to Treatment

REGARDING: Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures that will be done by the doctor or other members of the staff:

____ spinal manipulative therapy ____ palpation ____ vital signs ____ orthopedic testing
____ range of motion testing ____ basic neurological testing ____ postural analysis testing
____ radiographic studies ____ Other (please explain):

_____ Initial

REGARDING: X-rays/Imaging Studies

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case

_____ Initial

MINORS ONLY

I hereby request and authorize Dr. Abigail Tebbe to preform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select to 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.

_____ Initial

FEMALES ONLY: please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

- The first day of your last menstrual cycle was on ___/___ Date
- I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

_____ Initial

DO NOT SIGN UNTIL YOU HAVE READ AND UNSTAND THE ABOVE.
PLEASE CHECK THE APPORPRIATE BLOCK AND SIGN BELOW.

I have read the above explanation of the chiropractic adjustment and related treatment, or have read to me. I have discussed it with Dr. Abigail Tebbe and have had my 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 my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____/_____/_____
Patient or Authorized person's Signature Date

_____/_____/_____
HFW Staff Signature Date

