Informed Consent for the Chiropractic Patient

To the patient: Please read document and sign. It is important that you understand the information contained in this document.

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use this procedure to treat you. She/he may use their hands or mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", similar to the sound when you "crack" your knuckles. The cause of this sound is small gas bubbles being released in your joints, not of bones "cracking". When this happens, you may feel a sense of movement.

Analysis/Examination/Treatment: As part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, trigger point massage, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, ultrasound, cold therapy, Biofreeze application, electric muscle therapy, and traction therapy.

The risks inherent in chiropractic adjustment: As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy that are very rare, such as fractures or minor muscle pulls. It is common to feel stiffness or soreness following the first few days of treatment. Fractures are very rare occurrences and generally result from some underlying weakness of the bone. Stroke or vertebral artery dissection caused by chiropractic manipulation of the neck has not been officially proven, but continues to be anecdotal. The doctor will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would not come to the doctor's obvious attention, it is your responsibility to inform the doctor.

Authorization for the release of patient information: I hereby authorize Messer Chiropractic and Nutrition Center to provide other healthcare providers with information regarding my healthcare as deemed appropriate. I give my permission for the use of medical records, including x-rays and information shared during the process of examinations and treatment to be released to insurance companies, other doctors, health consultants and/or staff involved in my care.

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, related treatment, and risks involved. I have had all my questions answered to my satisfaction and know that I am able to request a copy of this consent form at any time. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to participate in the treatment recommended. I understand that if I do not wish to sign, I will not be able to receive any treatment from Messer Chiropractic. I hereby give my consent to chiropractic treatment at Messer Chiropractic and authorize any pertinent medical records exchange. I understand this consent to be effective until I am notified by Messer Chiropractic otherwise.

Print Name(s) of Patient(s): ______________________________

Patients' Signature: ______________________________ Date: ______________

Relation to Minor: ______________________________

Parent/Guardian Signature: ______________________________