CHIROPRACTIC SOLUTIONS

by dr julie

INFORMED CONSENT

You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo such care after being advised of the known risks. This disclosure is not meant to frighten or alarm you. It is simply to make you better informed in order that you may give or withhold your consent.

INTRODUCTION

CHIROPRACTIC SOLUTIONS by dr julie is staffed with licensed doctors of chiropractic. Chiropractic is a science which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) of the body as the relationship may effect the restoration and preservation of health. For your information, the following is routinely furnished to all who consider chiropractic care and treatment in this clinic.

NATURE AND PURPOSE OF CHIROPRACTIC

Adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by such subluxation(s). This is done with a chiropractic adjustment following a chiropractic examination which may include, but is not limited to spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiology examinations, and laboratory tests.

An adjustment is the application of a quick precise movement over a very short distance to the spine or extremity. There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. In addition, physiotherapy and/or rehabilitative procedures may be included in the management protocol.

Not only should you understand the benefits of chiropractic care and treatment in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contradict care, but should be considered in making the decision to receive chiropractic care. All health care procedures have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological injury, fracture, vertebral artery syndrome (VAS) including stroke and perhaps, death through complicating factors. Risks associated with physiotherapy may include not only the forgoing but also allergic reaction, muscle and/or joint pain.

Patient's Initials _____

Over →

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Dr. Julie L. Lyles Phone: 502/253-1135 Fax: 502/253-1136

AUTHORIZATION FOR CHIROPRACTIC CARE AND TREATMENT

I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE CHIROPRACTIC SOLUTIONS by dr julie TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

AUTHORIZATION TO CONTACT PRIMARY CARE PHYSICIAN

To ensure coordination of care, I authorize CHIROPRACTIC SOLUTIONS by dr julie to periodically convey to my primary care physician results of any diagnostic testing (i.e. x-rays), as well as information regarding my plan of care and outcomes.

Name of Physician: _____ Telephone # _____

Patient's Signature: _____ Date: _____

IF PATIENT IS UNABLE TO CONSENT:

PATIENT NAME: _____

REASON FOR INABILITY TO CONSENT:

- ☐ PATIENT IS A MINOR _____ YEARS OF AGE
- ☐ OTHER: (explain) _____

PERSON AUTHORIZED TO SIGN FOR PATIENT: _____

RELATIONSHIP TO PATIENT: _____

AUTHORIZED PERSON'S SIGNATURE: _____

DOCTOR'S SIGNATURE: _____

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