A WAY OF WELLNESS CHIROPRACTIC
1121 W SECOND ST
Bloomington, IN 47403

Informed Consent – Chiropractic Care

Andrew Pitcher D.C.
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Patients Name: ____

Instructions: This document relates to your Informed Consent for care. Please read carefully before signing.

General

I, the below-signed patient/individuals, have read this document in its entirety and understand the potential benefits and risk of the Care which you are recommending. I understand that there may be others forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that the Care Plan will list you as the "Rendering Provider," at any moment, other doctors in office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law have the same scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed above.

I do not expect you to be able to anticipate and explain all risk and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care weather I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risk of the Care: Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, dislocations, muscle strain, and 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. I understand that fractures are rare occurrences and generally results from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays.

I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge, I am not pregnant.

Other Potential Alternatives.

I understand that other treatment options for my condition may include self-administered, over-the-counter analgesics and rest; medical care with prescription drug such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment.

I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you are fully understand them.

Definitions.

"You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent.

I have had ample opportunity to explore other potential forms of care, has asked you all the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care. Under the new "good-faith estimate" clause part of the Affordable HealthCare Act, the charges for your first visit can range from $0.00-$500.00.

Patient's Name: ____

Patient's Signature: ____

Date of Signature: ___/___/___

Name of Parent / Guardian / Authorized Representative: ______________________________

Signature: ________________________________

Date of Signature: ___/___/___