INFORMED CONSENT FORM:

Please read this consent form, discuss it with your clinician if you would like to and then sign where indicated at the bottom.

Clinicians who use manual therapy techniques, such as joint adjustment or manipulation or mobilization and acupuncture are required to inform patients that there are or may be some risks associated with such treatment.

- 1. While rare, some patients have experienced muscle and ligament sprains or strains or rib fractures following spinal manual therapy. There have been reported cases of disc injuries following spinal manual therapy; such cases are also very rare.
- 2. There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilization. Such vertebral artery injuries may, on rare occasion, cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about one time per one million treatments.
- 3. Acupuncture techniques can occasionally cause local swelling, bruising or transitory increase in levels or distribution of pain or other symptoms. In very rare cases acupuncture has been reported as been associated with bodily infections or collapse of a lung.

Treatments provided at this clinic, including spinal adjustment, manipulation and/or mobilization and acupuncture, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. The risk of injury or complication from manual treatment is substantially lower than the risk association with many medications, other treatments and procedures given frequently as alternative treatments for the same forms of musculoskeletal pain and other associated symptoms.

Your clinician will evaluate your individual case; provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary. I give permission to the therapist to exchange information with my doctor and other medical specialist when necessary.

Acknowledgement

I acknowledge I have discussed, or have been given the opportunity to discuss with my clinician, the nature of chiropractic treatment in general, and my treatment in particular, as well as the contents of this consent.

Consent

I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs) and the use of acupuncture. I intend this consent to apply to all my present and future treatments at this clinic.

Date:/	
Patient signature (legal guardian)	Signature of guardian (where applicable)
Name (please print name of patient)	Name (please print name of guardian)
Signature of witness	Name (please print name of witness)

CREDIT POLICY: It is a policy of Brownlie Chiropractic to expect payment for treatment at the time of consultation. We accept Cash/Cheque/EFTPOS. HICAPS is available where applicable.