SPINE & SPORTS CHIROPRACTIC CARE OF CT, LLC

220 Farmington Ave., Farmington, CT06032

Tel: 860-269-3225 • Fax: 860-269-3227

www.spinesportscare.com

CONSENT TO EVALUATION AND TREATMENT

PATIENT NAME: ____

Thank you for choosing our practice. We are committed to providing you with quality health care. Part of our responsibility to you, our patient, is to keep you informed of the treatment and professional services. Please read the following, ask any questions, and sign. A copy can be provided upon request.

CONSENT TO EVALUATION AND TREATMENT

I hereby authorize Spine & Sports Chiropractic Care of CT, LLC and its licensed doctor(s), based on my complaints and the history I have provided, to undertake an evaluation and provide a treatment plan which may include spinal manipulation and other ancillary procedures considered therapeutically appropriate.

I hereby authorize and release the doctor(s) and whomever he/she may designate as his/her assistants to administer treatment including spinal manipulation and any other procedures as recommended by the doctor(s) as being therapeutically appropriate in my case.

POSSIBLE RISKS

I understand that, as with any health care procedure, there are certain risks and complications, which may arise. Although the incidence of complications associated with services are rare, anyone undergoing spinal manipulation/adjustment and therapeutic procedures during the course of their care should know of rare possible hazards and complications which may be encountered. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. In extremely rare circumstances, cerebrovascular injury or stroke could occur upon injury to arteries of the neck. A minority of patients may notice stiffness, or soreness after the first few days of treatment. In rare circumstances, the ancillary procedures could produce skin irritation, burns, or minor complications.

I do not expect the doctor(s) to be able to anticipate all risks and complications and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure(s) which the doctor(s) feels at the time, based upon the facts then known, are in my best interest.

There are reasonable alternative treatments to these procedures, each with their own associated risks. These may include rest, home applications of therapy, prescription or over-the-counter medications, exercises, possible surgery, and non treatment.

I understand and accept that:

- **I have the right to withdraw from or discontinue treatment at any time and that the Spine & Sports Chiropractic Care doctor(s) will advise me of any material risks in this regard.**
- **That neither chiropractic, physical therapy, nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor(s) during the course of my care and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.**
- **That it is not reasonable to expect the doctor(s) to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.**

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the evaluation and treatment I may receive. My signature below acknowledges my consent to the evaluation and proposed course of care and treatments by Spine & Sports Chiropractic Care of CT, LLC.

____
Patient's Printed Name

____ ________________________________
Signature (Parent/Guardian if patient is a minor) Date