INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Gregory P. Skye, D.C. Shannon M. Skye, D.C. Collin G. Skye, D.C.

I hereby request and consent to the performance of chiropractic treatments also known as chiropractic adjustments or chiropractic manipulative treatments, and any other associated procedures: physical examination tests, diagnostic x-rays, physical therapy procedures etc. on me by the doctor of chiropractic named above and or other assistants and/or licensed practitioners.

In our experience, the most effective treatment for spinal joint dysfunction involves manipulation of spinal joints. Specifically, manipulation can reduce pain, tenderness, and muscle spasm and can improve the mobility of your spine, as well as many other beneficial effects.

As with all other forms of treatment, manipulation of the spinal joints has some unwanted side effects of which you should be made aware. A very small percentage of patients (less than one percent) may experience discomfort after a manipulation, ranging from aching feeling of stiffness to actual soreness. This may, depending on the type of condition you have and for how long you have had it, be an expected consequence of the form of treatment. In the very rare instance (from one in one million to one in ten million) serious neurological damage may occur as a result of this type of treatment.

We at Skye Chiropractic take every precaution in our diagnosis and treatment to minimize these unfortunate occurrences. Although we offer spinal manipulation with the utmost confidence in its proven benefits, you have the choice to decide not to have this type of treatment. There are other forms of treatment available to you here, including soft tissue therapy, electrical therapy and mobilization, among others.

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

Again, it is my responsibility to make it known any condition(s) I am suffering from which would otherwise not come to the attention of the doctor. The doctor is licensed in a special practice and is available to work with other types of providers in your health care regime.

I am authorizing Skye Chiropractic to proceed with any treatment deemed necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request. I intend for this consent to cover the entire course of treatment for my present condition(s) for which I seek treatment.

I have read the above statements and have had the opportunity to discuss this with my treating doctor and have any questions answered. I am of legal age of consent. Please sign below if you understand the described risk and consent to the treatment.

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Printed Name of Patient

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Signature of Patient Date

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Signature of Representative (if patient is handicapped) Witness