

I \_\_\_\_\_ do hereby give my consent to the acupuncture and chiropractic treatments and other procedures within the scope of the practice of acupuncture and chiropractic on me (or on the patient named below, for whom I am legally responsible) by the practitioner named below and/or other licensed practitioner who now or in the future treats me while employed by, working or associated with or serving as back-up for the doctor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, adjustments involving movement of the joints and soft tissues, physical therapy, exercises, acupuncture, herbs, and nutrition. I also understand that some, if not all of the procedures have been designated "unproven" by the Colorado Board of Chiropractic Examiners and that its effectiveness has not been demonstrated. Although spinal adjustments are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

**Possible risks and probability:** I understand and am informed that there are inherent risks in any and all treatment delivered by any health care provider, ranging from taking a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustment. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to the most serious would include: muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to intervertebral discs, nerves, or spinal cord (very rare). The risks involved in the treatment of the neck would include any on the proceeding list but also include the remote possibility of cerebrovascular injury, or stroke (very very very rare chances are one in one million to one in ten million.) A minority of patients may notice stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare).

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risk may occur. The herbs and nutritional supplements (which are from plants, animal and mineral sources) that have been recommended are traditionally considered safe in a practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

**Treatment Results:** I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits nor guarantee to the outcome of these procedures.

**Alternatives to Treatment:** Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter-medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain and/or inflammation. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious and long-term use or overuse of medication is always a cause for concern.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve or joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

No Treatment: I understand potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have made my decision voluntarily and freely.

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Patient Name: \_\_\_\_\_

-----Office Use Only-----

I certify that the above accurately describes the above named client's status during the informed consent process.

Based on my personal observations, medical history and direct conversation with the client, I conclude that throughout the consent process the patient was:		
Resolute in denying the use of alcohol and/or Recreational drug use prior to consent. _____	A & O X 3 _____	
On prescription/OTC medication but unimpaired _____	Of legal age _____	Coherent and lucid _____
Proficient in understanding the English language _____		Assisted in understanding by an interpreter _____
Interpreter's Name _____	Relationship _____	Disoriented as to _____

Date: \_\_\_\_\_ Doctor's Signature: \_\_\_\_\_ Office: Rocky Mountain Wellness, Inc.