Disclosure and Informed Consent for Chiropractic Treatment

The nature of chiropractic treatment: Chiropractic focuses on the nervous system and the spinal cord. During chiropractic treatment, the doctor will use his/her hands or a mechanical device in order to align your spine to correct interference to the nervous system and improve the body’s ability to control and coordinate many functions. You may feel a “click” or “pop”, similar to when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joint, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury (i.e., stroke) could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications from taking a single aspirin. The risk of stroke has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare.”

Other treatment options that could be considered may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multiple of undesirable side effects and potentially patient dependence.

- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is probable that delay of treatment may complicate the condition, and make future rehabilitation more difficult.

Unproven procedures: Some chiropractic procedures are deemed “unproven” by the Colorado State Board of Chiropractic Examiners. Unproven procedures are those where the effectiveness has not been demonstrated and include, but are not limited to soft or cold laser for uses not approved by the FDA; Reams procedures; iridology; reflexology; contact reflex analysis; diagnostic spinal ultrasound for the use of diagnosing inflammation, swelling, or other pathology; and any practice system that does not include a complete evaluation prior to treatment, relies upon methods that are not generally recognized in the profession, and is represented as a means of attaining spiritual growth, comfort, or well-being.
Release of patient records: Pursuant to § 25-1-802, C.R.S., every patient record is available to the patient upon submission of a written authorization-request for inspection of records, dated and signed by the patient, at reasonable times and upon reasonable notice. A copy of such records, including X-rays, shall be made available to the patient or the patient's designated representative, upon written authorization-request for a copy of such records, dated and signed by the patient, within seven (7) business days and payment of copying costs at $.25 per page.

Chiropractic-patient relationship: Patient records and confidential communications between the chiropractor and a patient in the course of treatment will not be disclosed unless such patient gives his or her consent prior to disclosure. This confidentiality does not apply when one of the exemptions in § 12-33-126(2), C.R.S., exists. It is not proper for a chiropractor to engage in an intimate relationship with a patient during the course of care or within six months immediately following the termination of the chiropractor’s professional relationship with the patient.

Consent to treatment: I understand the hazards and potential dangers involved in treatment by means of chiropractic. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made. I understand that it usually requires a series of chiropractic treatments to significantly change a condition and receive benefit. It is understood that options exist for treatment and all treatments are choices between risks and benefits. I understand that every effort will be made to explain my diagnosis, treatment and risk factors; however, if there are any questions or concerns, I will bring this to the immediate attention of Dr. Washington. I hereby consent to evaluation and treatment rendered according to the applicable standards of care including those that have been designated “unproven”.

Consent to X-ray: I authorize the performance of diagnostic x-ray examination of myself which may be considered necessary or advisable in the course of my examination and treatment.

Consent to payment and assignment of benefits: I hereby authorize payment to be made directly to Kelvin M. Washington, D.C., Inc., for chiropractic and related services rendered by insurance coverage. I shall be personally responsible for any unpaid balance. I understand that if my insurance company does not pay outstanding charges within 90 days of the billing, I will be financially responsible for those charges. Balances over 90 days may be subject to interest of 1.5% per month (18% annually), collection charges, court costs, and related attorney fees at $200 per hour. I authorize the release of any information concerning my examination, treatment, or other protected health information for payment purposes.

My signature indicates that I have read and fully understand the above information regarding chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to such treatment.

Printed Patient Name ___________________________ Patient Signature ___________________________ Date ___________________________