Fountain City Chiropractic & Rehabilitation, Inc.
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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The Nature of Chiropractic: The doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" such as the noise when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as 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 one, muscular strain, ligamentous sprain, dislocations, of joints or injury to intervertebral discs, nerves, or the spinal cord. Cerebrovascular injury or 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 are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or 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 the stomach, liver, 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 multitude of undesirable side effects and patient dependence in a significant number of cases. Hospitalization in conjunction with medical care adds risks 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 quite probable that delay of treatment will complicated the condition and make future rehabilitation more difficult.

Unusual risks: *I have any/all unusual risks of my case explained to me.*

I have read the explanation above of chiropractic treatment. 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 consent for such.

*Printed Name:*_____

*Signature:*_____ *Date:*_____

Office Policies

If you are paid directly by an insurance company and/or third party payer, please provide us with payment and a copy of the explanation of benefits within ten (10) days of receipt.

If your treatment is the result of a work related injury or a personal injury – Worker's Compensation, your attorney or the third party payer will be billed for services related to those claims. Any services that are not the result of a work-related injury or personal injury will be billed to you and/or your health insurance.

While a patient is off work under a work excuse, it is imperative that he/she maintain his/her prescribed treatment plan. If it appears that Fountain City Chiropractic & Rehabilitation, Inc is being used to commit a possible fraud, the work excuse will be canceled by notifying the employer.

Agreement, Assignment and Information Release

I agree to cooperate with Fountain City Chiropractic & Rehabilitation, Inc to help them secure payment for services provided. In addition, I agree to provide requested information to named facility and/or third party payer in order to assist with the processing or determination of status on any claim. I assign my insurance benefits to Fountain City Chiropractic & Rehabilitation, Inc. and authorize them or their agents to bill and release information to my insurance company, attorney and/or third party payer. I authorize my insurance company, attorney and/or third party payer to provide the above named facility or their agents with any information concerning my claim, their services and/or payment for the services provided. In addition, I authorize Fountain City Chiropractic & Rehabilitation, Inc to have billings and other information reviewed by outside counsel before submission,

I hereby acknowledge that I have read, understand and agree to the above provisions.

Printed Name:_____

Signature:_____ Date:_____

Staff Signature:_____