VAUGHAN
PHYSIOTHERAPY
CLINIC

PLEASE READ CAREFULLY

I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

Chiropractic

I hereby request and consent to their performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic.

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatments. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament sprains as a result of manual therapy techniques;
b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because strokes sometimes cause serious neurological impairment, and on the rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.
c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck any back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including electro-acupuncture by the above named doctor or another duly authorized doctor/there in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I do not expect the doctor to be able to anticipate and explain all the possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form. I have also had an opportunity to ask question about its content and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Females Patients

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

Informed Consent Chiropractic, Physiotherapists & Other Therapists

I have had an opportunity to discuss with the doctor of chiropractic, physiotherapists, therapists and staff members and/or with other office or clinical personal, the nature and purpose of therapeutic interventions and other procedures utilized in this office. I understand that results are not guaranteed. There are some risks associated with treatment although rare and are not limited to sprains/strains, fractures and burns from modalities. I have read and understood the above and I consent to all examinations and care as deemed appropriate by the doctor of chiropractic, physiotherapists, and other therapists practicing in this office for my present condition, and for any future condition for which I may seek care. I realize that I may ask any questions to the doctor of chiropractic, physiotherapists, and therapists either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

Patient Name: ______________________________ Date: ______________________________

Signature: ___________________________________

The patient listed above has been verbally informed and understands the contents of this consent form, their plan of management, and return of findings.

Provider Signature: __________________________