Chagrin Valley Chiropractic and Acupuncture Center

Informed Consent to Chiropractic Examination and Treatment

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care.

The types of complications that have been reported secondary to chiropractic care include general soreness similar to post-exercis soreness, short term aggravation of symptoms, sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke,and possibly, ultimately death.

Prior to receiving chiropractic care a health history, physical examination, and possibly x-rays will be completed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will help in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

There are other treatment options for your condition. These will be discussed by Dr Nassif after the examination has been performed and before treatment is started. These other options may include but are not limited to: medical care, physical therapy, massage therapy, acupuncture, and no treatment at all.

By signing below, I acknowledge that:

- I have read, or had read to me, the information on this consent form,
- I understand the possible risks and complications involved. I have had the opportunity to discuss this consent form with Dr Nassif. I understand that I can request more information at any time if desired.
- I consent to receiving treatment that involves the above procedures.
- I understand that I have the right to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.

_____ _____ _____

Patient Name (please print) Patient (or Guardian) Signature Date

If a Guardian has signed, please print your name: _____

_____ _____

Ivan Nassif, MS, DC, RAc Date

Acknowledgement of Receipt of "NOTICE OF PATIENT PRIVACY PRACTICES"

I the undersigned have read and agree with the privacy policies of Chagrin Valley Chiropractic and Acupuncture center.

_____ _____

Patient (or Guardian) Signature Date