

Integration Therapy, LLC

460 St. Michael's Drive, Ste 100, Santa Fe, NM 87505

phone: 505.780.8783 fax: 505.780.8794 www.integrationpt.com

INFORMED CONSENT FOR MANIPULATION THERAPY

Clinicians who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____ do hereby give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that the procedures may include manipulation involving quick movement of the joints and soft tissues.

Although spinal manipulation is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies may render a patient susceptible to injury. When a complicating condition is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from spinal manipulation are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million treatments. (Once in one million is about the same chance as getting hit by lightning.) Some estimates from medical literature cite the incidence as one in ten million treatments. One in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. I am aware there are different studies quoting different incident rates. I understand that it is **EXTREMELY IMPORTANT** to tell my healthcare provider if I have experienced any severe and sudden onset of headache, neck or facial pain or numbness that is unlike anything I've ever experienced before as these may be warning signs that a serious condition is developing.

Evaluations will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand there are beneficial effects associated with these treatment procedures that may include but not be limited to decreased pain, improved mobility and function and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that clinical healthcare is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my therapist.

Alternative Treatments Available

Reasonable alternatives to manipulation have been explained to me. I agree that if my therapist believes manipulation is the safest and most effective approach to my condition then I choose to agree.

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I have read or have had read to me the above explanation of spinal manipulation. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of patient: _____

Signature of witness: _____

Date and Time: _____

(SECTION BELOW TO BE COMPLETED BY HEALTH CARE PROVIDER)

PATIENT STATUS AT TIME OF INFORMED CONSENT PROCESS

Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was:

of legal age oriented x 3 coherent and lucid

on prescription/OTC medicated but unimpaired

proficient in understanding the English language assisted in understanding by an interpreter

Name: _____

resolute in denying the use of alcohol and or recreational drug use prior to consent

disoriented as to _____ unable to give legal consent

consent given through legal guardian

Name: _____

Relationship: _____

Signature of Clinician

Date