CAROLINA
Active Health
CHIROPRACTIC

Informed Consent

Consent for Examination and Treatment:

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, exercise specialist, massage therapist, physical therapist, and/or any other person who may be employed by or engaged in practice in this clinic. This also includes any modality utilized in my treatment including but not limited to electrical stimulation, heat, Normatec, laser therapy, blood occlusion, IASTM, stretching, and taping. Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment.

I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgements based upon facts and information known to the doctor. The doctor uses this judgement to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgement. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests. I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which rarely includes, but not limited to fractures, disc injuries, strokes, sprains/ strains and I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

Additionally, as part of treatment I will participate in a provided therapeutic exercise program with goals to:

- Strengthen your muscles
- Increase your cardiovascular endurance, range of motion, and flexibility
- Decrease overall pain
- Return you to full duty, non – restricted work status and lifestyle

The process of strengthening and conditioning are a form of “controlled strain” and there is a risk of aggravation of injury. It is therefore imperative that you communicate to the physician, any aggravation or injury that you may observe during the rehabilitation process. *For example the best exercise for you, if performed too early in your condition, may be your worst enemy if performed too soon.* Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

Success of any rehabilitation process lies in the combined efforts of you and your provider. The “team” approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit for your rehabilitation program. Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager if applicable.

I understand and consent to treatment_____ (initial)

By signing below, I agree and intend this consent to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: Are you currently pregnant? Yes or No If currently pregnant-how many weeks? _____

If not pregnant, Date of last menstrual period _____

Patient name: (Print) _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship of authority if not signed by the patient: _____

Witness name: _____