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Shared Decision Making and Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed. In our office we offer Physical therapy, Chiropractic care, Massage Therapy and Acupuncture. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. Potential benefits of treatment are to decrease pain and muscle spasm. Restore proper joint mobility, reduce swelling and inflammation, and improve neurological functioning and overall well-being. As with all types of health care interventions, there are some risks which are extremely rare, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, skin irritation from electrical stimulation including but not limited to hot packs and ice, fractures, disc injuries, strokes, dislocations, strains, and sprains.

It is also important that you understand there are treatment options available for your condition, and in our office we try to offer as many options as possible which will be individualized and specific for each patient to fit their needs and improve their overall health.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive treatment as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek treatment from this office.

Patient Name: _____

Signature: _____

Date: _____