CHIROPRACTIC RELEASE WAIVER & INFORMED CONSENT

Print Name Sport (if applicable) Date

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

In being permitted to use the facility, services and programs of Range of Motion Chiropractic for any purpose, including, but not limited to observation, use of facility equipment or participation in any off-site program affiliated with Range of Motion Chiropractic, the undersigned for himself, herself or for such participation of their children, personal representative, heirs or next of kin, hereby acknowledges, agrees and presents that he or she has immediately upon entering or participating will inspect and carefully consider such premises, facilities and programs.

1. **CONSENT TO TREATMENT:** One of the treatments that may be employed under sports medicine chiropractic is spinal and or extremity manipulative therapy. The undersigned requests and consents for Erica D. Witter-Davis, D.C. and those under her direction at Range of Motion Chiropractic, to perform evaluation and treatment for all chiropractic related conditions, whether pre-existing or current. The undersigned grants permission to undergo any diagnostic or therapeutic treatment recommended by the chiropractor including but not limited to physical, orthopedic, psychological, and neurological examinations, diagnostic imaging, chiropractic manipulation, myofascial release, strength and conditioning exercises, electrical muscle stimulation, first aid care, sports taping techniques and bracing.

2. **RISKS:** As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, bruising and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Doctor will make every reasonable effort during the examination to screen for contraindications to care: however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

3. **THE PROBABILITY OF THOSE RISKS OCCURRING:** Fractures are rare occurrences and generally result from some underlying weakness of the bone which will be checked during your history intake, physical examination and X-ray. Strokes have been the subject of tremendous disagreement. The incidence of a stroke is exceedingly rare and is estimated to occur between 1/1,000,000 to 1/5,000,000 neck adjustments. The other complications listed are also considered rather rare.

4. **AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS:** Other treatment options for your condition may include: self-administered, over-the-counter analgesics, rest, hospitalizations, surgery, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers.

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

5. **RISKS AND DANGERS TO ATTENDANT TO REMAINING UNTREATED:** Remaining untreated may allow the formation of adhesions and reduce mobility, which may cause a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

6. **RELEASE OF HEALTH INFORMATION:** The undersigned authorizes the release of protected health information as deemed appropriate by the Doctor concerning the physical condition to any third party for the following, but not limited to insurance payment, worker's compensation, emergencies, public health, judicial and administrative proceedings, law enforcement, public safety, and changes of ownership. The undersigned also agrees for the Doctor to obtain all records including, but not limited to all chart entries, diagnoses, test results, and reports for the same purpose(s).

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BLEOW

I have read or have had read to me the above explanation of the sports chiropractic adjustment and related treatment. I have discussed it with my attending sports chiropractor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

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Print Your Name (Parent/Legal Guardian Name)

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Signature (Patient/Legal Guardian if patient is under 18)

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Date

FOR OFFICE USE

____
Doctor's Name

____
Doctor's Signature

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Date