Bowman Chiropractic

3868 East Robinson Road
Amherst, NY 14228
(716) 564-2225

7312 Niagara Falls Blvd
Niagara Falls, NY 14304
(716) 236-7176

Fax 888-484-2163
bowmanchiro@gmail.com

Informed Consent to Chiropractic Care

This notice describes what a patient may expect as it pertains to treatment in this office and indicates the patient's consent to submit to a course of care.

CHIROPRACTIC CARE AND TREATMENT. I have and have had an opportunity to discuss with the chiropractic doctor, or other office or clinical personnel named below, the nature and objective of chiropractic care, the physical examination and other diagnostic tests and procedures used by chiropractors including any necessary orthopedic, neurological, laboratory tests, imaging studies (X-rays, CT scans, MRis, etc) and other procedures; chiropractic care and treatment protocols, including chiropractic adjustments, manipulation, mobilization and other therapies utilized by this office/practice in the care of my condition. Taken together, these procedures and protocols to will be referred to as the office/practice's "chiropractic examination and treatment methods." Furthermore, it also has been communicated to me and I understand that every patient reacts differently to care, and that treatment results and outcomes cannot be guaranteed. It also has been explained to me that if any tests were performed outside of this office/practice (e.g., laboratory or other diagnostic procedures), that the doctor or other staff member or clinician will notify me of the results at my next scheduled appointment.

NATURE OF CHIROPRACTIC TREATMENT. I have been informed that, on occasion, some patients experience increased discomfort following chiropractic care and treatment. Chiropractic physical examination and treatment may involve bending, twisting, mechanically challenging your joints and testing your muscle strength, and it can possibly lead to temporarily feelings soreness or pain. During treatment, the doctor may use his or her hands or mechanical devices to move, adjust, manipulate your joints and mobilize soft tissues (e.g. muscles, ligaments). A "crack" or "pop" sound is often produced in some of the joint manipulation procedures and is caused by a separation of the smooth joint surfaces in much the same way a suction cup produces a popping sound when it is removed from glass or other smooth surface. Although a popping sound is not necessary, it is often a natural effect of joint movement.

PERMISSION FOR PHYSICAL CONTACT. It has been explained to me, and I understand that, in the course of various chiropractic examination procedures and treatment methods, the doctor of chiropractic or other clinical staff may have to examine and physically contact portions of my body. I understand that any contact of an intimate or sexual nature is illegal, unethical, never a part of chiropractic professional examination or treatment, and is prohibited. Nevertheless, I also realized that some chiropractic procedures may require that the doctor or clinician contact me in some physically sensitive areas - such as during a procedure known as a "lumbar roll" where the doctor may contact with my rump (the posterior, superior spine of the Ilium) to adjust my sacroiliac joint, or some other similar or analogous procedure. I understand, however, that before any sensitive contact or procedure occurs the doctor or other clinical staff member will explain to me what is to be done, how it will be performed, why it will be performed, that I may refuse that particular test or procedure, or alternatively that I may request that another member of the staff be present for my safety and protection, and finally, that I will be given the opportunity to signal the doctor or clinician when I am ready to receive the test or procedure. I also agree that if I ever have any questions, doubts or misgivings about the appropriateness of such contact I can discuss my concerns with the doctor, or other office or clinical staff member. If for any reason I am reluctant to discuss these concerns directly with my doctor or clinician, or if I feel unsatisfied with the explanation given, I agree to seek a professional, third-party consultation from another licensed chiropractor mutually agreed upon by me and my chiropractor or clinician, or alternatively, I may contact the New York State Chiropractic Association (518-785-6346) or the state licensing agency - the New York State Education Department, State Board for Chiropractic (518-474-3817 X190). The doctor, clinician and I agree to these stipulations to ensure that no misunderstandings or uncomfortable feelings arise as a result of physical contact between me and the doctor or other office/practice clinician. Finally, it is my understand that I may revoke this permission at any time by a mutual exchange of written acknowledgments indicating that permission for any further physical contact by the doctor or other staff member with my person is prohibited. After having the foregoing information explained to me I hereby request, consent and submit to the office/practice's chiropractic examination and treatment methods performed as explained to me.

RISKS OF CHIROPRACTIC CARE AND TREATMENT. I understand and have been informed that there is risk of side effects and complications anytime a doctor, provider or other clinician is asked to intervene in a healthcare encounter with a patient. I have been informed by the office/practice of the following: that although the risk of serious complication from chiropractic treatment is rare and unlikely, nonetheless, rare events ranging from relatively minor muscle soreness, aches, sprains and strains, to injuries to the spinal discs, nerves and cord, or an occasional fracture or dislocation in compromised patients with certain concomitant diseases and illnesses have been reported in the scientific literature; that cerebrovascular accidents, such as a stroke, have also been reported; that these are generally attributed to an underlying defect in a vertebral or basilar artery known as a spontaneous dissection and that these have been estimated to occur in one-to-a-million to one-in-forty-million cases of chiropractic, osteopathic, physical therapy and medical manipulation; about the same probability of stroke from turning your head or having your hair washed in a salon ("beauty parlor stroke'). In some of these instances, however, these dissections were not proximate in time or location to the treatment rendered, and consequently, it cannot be said with any certainty that the specific treatment caused the stroke, aggravated an underlying, pre-existing condition, or the treatment given was totally unrelated to the resulting stroke. It was explained to me that the most common and likely side effect of treatment will be muscular stiffness or soreness, described by some as akin to the ache people experience after exercising the first time in a long time; and that these effects are often transient and temporary. I was instructed that if I experience any increased discomfort following treatment, that I should apply ice to, and rest the affected area. I was also told that if I become concerned about any post-treatment discomfort or, I should develop of any new or unrelated symptoms, I should call the number listed below for emergency attention available twenty-four (24) hours a day. I also understand that if for some reason I am unable to reach or contact that doctor, that I should telephone my personal, primary care doctor or present myself to the nearest hospital emergency room. It was explained to me and I do not expect the doctor to be able to anticipate all the potential risks or complications. Nor do I expect that the doctor or other clinician to provide me assurances that i will not experience a negative outcome. Nonetheless, I wish to rely on the doctor to exercise his or her best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels are in my best interest, based upon the facts as then known at the time.

CONSENT. By signing below in conjunction with the doctor, or other office or clinical personnel, I acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning. By signing below, I agree to submit to the above-named chiropractic examination and treatment methods. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment from the office/practice indicated below.

Signature_____ Date_____