Carey Chiropractic, P.A.
DR. MARISA CAREY
103 POPLAR ST., P.O. BOX A
FRUITLAND, MD 21826
TELEPHONE: (410) 546-2225
FAX: (410) 546-4488

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____ (Name (Print)), of _____ (City/ST) do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, 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 like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
- **Stroke**: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
- **Physical Therapy Burns**: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

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TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including 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 the practice of medicine, including chiropractic, 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 doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

- **Medications**: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relieve, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

- **Rest/Exercise**: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

- **Surgery**: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

- **Nontreatment**: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increase inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

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I have read or have had read to me the above explanation of chiropractic treatment. 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: _____

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PERMISSION TO EXAMINE AND TREAT A MINOR

I, _____, hereby give my consent to Dr. Marisa Carey,
(Name of Parent or Guardian)

of Carey Chiropractic, P.A. to examine and treat _____
(Name of Patient)

under the scope of Chiropractic examination and treatment.

I understand that Dr. Carey requests I be present during all examinations and chiropractic treatments, however, if I am unable to be present, I give my permission for all procedures to be performed.

_____ _____
Witness Parent/Guardian Signature

_____ _____
Date Print Parent/Guardian Name

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DR. MARISA CAREY
103 POPLAR ST., P.O. BOX A
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Date_____

Dear _____

Please be advised that I give my permission and would appreciate your sending copies of history, treatment plans, lab work, x-rays and all other information you have secured as a result of my treatment to Carey Chiropractic, P.A., P. O. Box A, Fruitland, MD 21826. You may fax this information to 410-546-4488. Thank you in advance.

_____
Patient Signature

_____
Name

_____
Social Security Number

_____
Date of Birth

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Established Patient Authorization

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state that specific restriction and to whom you want the restriction to apply.

Your Chiropractor is not required to agree to restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to choose another Healthcare Professional.

Do we have permission to:

Leave a message to confirm an appointment on your answering machine: YES ____ NO ____
Leave a message for a return call at your place of employment: YES ____ NO ____
Leave a message with your spouse/significant other for a return call or appointment reminder YES ____ NO ____
Discuss your medical condition with any member of your household? YES ____ NO ____

If YES, whom:

_____ Restriction: _____ Relationship: _____

_____ Restriction: _____ Relationship: _____

_____ Restriction: _____ Relationship: _____

Please provide the following information:

Emergency Contact: _____ Phone: _____

Emergency Contact: _____ Phone: _____

_____ _____
Patient Signature Date

CAREY CHIROPRACTIC, P.A.
POBOXA 103 POPLAR ST.
FRUITLAND, MD. 21826
(410)546-2225

Patient Authorization - Release of Additional Personal Health Information

I, [Patient Name] _____, **hereby authorize the release of my reproductive health information as described below**:

_____

_____

Recipient of Information

I authorize the disclosure of my personal health information regarding – mental health and any necessary or previous care, drug use and/or addiction to the following individual(s) or entity(ies):

_____

Name of Person &/or Provider/Organization

_____

Address / Phone Number

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative. After this period, the authorization will expire, and any further disclosures will require a new authorization from me.

Patient Rights

Right to Terminate or Revoke Authorization

I understand that I have the right to revoke this authorization at any time by providing written notice to the healthcare provider. Revocation of this authorization will not apply to information disclosed prior to the revocation.

Disclosure Limitations

I understand that the information disclosed may include details of my reproductive health history, treatments, and services received. I also understand that I have the right to specify limitations or restrictions on the information to be released.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

Non-Discrimination Clause: I acknowledge that the release of my reproductive health information shall not result in discrimination or bias in the provision of healthcare services, and that my reproductive choices will be respected and upheld by the recipient(s) of the disclosed information.

Signature and Date: I hereby consent to the release of my reproductive health information as specified above. I understand the purpose of this disclosure and agree to the terms outlined in this authorization.

_____ _____

Patient or Legally Authorized Individual Signature Date

_____ _____

Print Patient's Full Name Time