AVIVA INTEGRATIVE HEALTH LLC
CHIROPRACTIC INFORMED CONSENT

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment, manipulation, or management of my condition(s). Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare.

Following are the known risks:

Temporary soreness or increased symptoms or pain: It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Dizziness, nausea, flushing: These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures: When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse: Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

Other risks: associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

Bruising: Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care. I have had an opportunity to discuss with Dr. Mary Sanders the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as with the practice of medicine, chiropractic care carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect Dr. Mary Sanders to be able to anticipate and explain all risks and complications. I consent to rely on Dr. Mary Sander's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts.

I have read the above statement of consent. I have also had an opportunity to ask questions about my consent, and by signing below I agree to the above named chiropractic procedures to be administered by Dr. Mary Sanders. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

I have read this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with Dr. Mary Sanders and have had these questions or concerns answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (Print)_____ **DATE OF BIRTH**_____

_____ _____

(PATIENT | GUARDIAN SIGNATURE) **(DATE)**

CLINICIAN ONLY

Based on my personal observation and the patient's history, I conclude that throughout the informed consent process the patient was:

□ OF LEGAL AGE □ APPEARS UNIMPAIRED □ FLUENT IN ENGLISH □ INFORMED CONSENT GIVEN

_____, **D.C.** _____

(D.C. SIGNATURE) **(DATE)**

PATIENT ACKNOWLEDGEMENT

Please read thoroughly. Initial your acknowledgement, then sign and print your name and date. Thank you.

NO INSURANCE BILLING

☐ I understand that Aviva Integrative Health must be paid directly when services are rendered. Aviva will not send billing to my insurance company or third-party payor. Aviva will provide to me upon request a suitable Superbill so that I may submit for reimbursement.

GUARANTEE OF PAYMENT

☐ I personally guarantee payment of all charges incurred for treatment in accordance with the rates and terms of Aviva Integrative Health.

CANCELLATION POLICY

☐ Aviva Integrative Health requires 24-hour advance cancellation notification for all appointments. I understand that I must notify Aviva Integrative Health at least 24 hours in advance to avoid FULL charge for a missed appointment.

SIGNATURE (PATIENT|GUARDIAN)	**PRINT NAME**	**DATE**