BACK  to Health Clinic

Informed Consent

The doctors and therapists at BACK to Health Clinic strive to provide treatments that offer a positive beneficial result. Our goal is to provide care that is both comfortable and effective. Treatments are generally very comfortable. If you develop questions, concerns or discomfort, please let us know so that we can help make your visit more enjoyable. Your communication will help us to provide you with an optimal positive experience.

Back to Health Clinic offers a variety of procedures, and since every patient's treatment is unique, your personalized treatment may include some or all of the following treatment procedures:

- Adjustments of the spine or extremities
- Heat pack application
- Massage therapy
- Spinal traction
- Ultrasound
- X-rays
- Nutritional counseling
- Paraffin wax or lotion application
- Laser
- Electrical stimulation modalities
- Gym exercise rehabilitation

WE BELIEVE ALL PROCEDURES WE PROVIDE TO BE SAFE AND EFFECTIVE. All medical procedures we provide may have inherent potential risks, but are extremely rare. However, allowing conditions to worsen when care is needed may be an even more serious risk to your health. We strive to take every precaution to provide quality care so that the benefits outweigh the risks. Complications may include soreness, skin discoloration, bone or soft tissue injury, neurological injury, allergic reaction to lotion, heat burn, neck or back pain, headache, or other unforeseen issues. Notify the care provider if you feel you may be experiencing any unusual symptoms so that the session can be modified for your comfort.

WE BELIEVE WE ARE THE TREATMENT OF CHOICE FOR MOST NERVE, MUSCULO-SKELETAL or PHYSICAL INJURY COMPLAINTS. Alternatives to chiropractic care may include home exercise, bed rest, stretching, weight control, physical therapy, and symptom control with acupuncture, homeopathic, or medicines. *(None of these options are without risk either).*

Please write any questions or concerns you wish to discuss before proceeding:

_____

_____

DO YOU ACCEPT TREATMENT? *(Initials)* _____ [YES] _____ [NO]

I have consulted with the care provider regarding any concerns or questions I have about the treatments and procedures offered. I have been informed of the risks and notified of alternative care options.

Minor Patient's Name: _____ Relationship to Minor: _____

_____/_____ _____

Parent/Patient Signature & Printed Name Date

_____ __ _____

Doctor's Signature Date

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