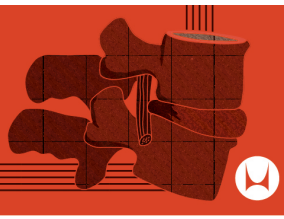
GONSTEAD CHIROPRACTOR
Hoyne Chiropractic . 0424 176 405



Informed Consent to Chiropractic Care

The information on this form is and will remain strictly confidential

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures, which you should be informed about. Please read the following carefully

1. I acknowledge that I have discussed with my Chiropractor, the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like. In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (current statistics eg between 1 in 2 million to 1 in 5.85 million - Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (current statistics eg less than 1 in 139,000) and the low back (current statistics eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible."

2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me. Details: _____

   _____

3. I have had the opportunity to discuss the proposed care with my Chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed Chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.

4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

6. I hereby acknowledge my consent to the performance of the proposed Chiropractic care by my Chiropractor and/or any other Chiropractor working in this clinic. I understand that I can withdraw consent at any time.

_____ _____

Patient Name (Printed) Patient Signature

(Parent or Guardian must sign if patient under 18 years of age)

_____ _____

Chiropractor Name (Witness) Chiropractor Signature

____ / ____ / _____ Date

Privacy Policy

The office is committed to the privacy of its patients. Personal information is treated as confidential and is used only for the purpose for which it was collected. Information kept on file will not be release to a third party without the express consent of the patient or as required by law.