INFORMED CONSENT

Pennsylvania State Law requires health care providers to obtain your **INFORMED CONSENT** prior to examination and treatment. You have a right as a patient to be informed about your condition, the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. The purpose of this form is to inform you, not to alarm you. What you are being asked to sign is a confirmation that you have been informed of the following:

EXAMINATIONS & X-RAYS This office does not perform in-house x-rays. All radiological services are referred to an outside facility and results are reviewed by a board certified radiologist. This ensures that we receive the highest quality images with the lowest amount of risk.

CHIROPRACTIC ADJUSTMENT/ CHIROPRACTIC MANIPULATIVE THERAPY (CMT) The doctor will use his hands and/or a mechanical device upon your body in such a way as to move or manipulate your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, which is not cause for alarm. **There are some material risks involved in doing these procedures as follows:**

- **Pain:** Chiropractic Manipulation, Physical Modalities (such as Electrical Stimulation, Ultrasound, Cold Laser Therapy, Trigger Point Therapy, etc.), or other treatments may result in a temporary increase in soreness in the area receiving treatment.

- **Rib Fractures:** Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate, gentle treatments are used, minimizing the possibility of fractures to the ribs.

- **Disc Injury:** Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems (1). Occasionally, chiropractic treatment may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury at *about 1 serious complication per 100 million low back manipulations* (2).

- **Vertebral Artery Dissection (VAD)/Stroke:** The overall incidence of vertebral artery dissection/stroke in the general population is about *2 per 1000 people* (3). Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke secondary to chiropractic adjustment/manipulation may occur *1 per 100,000 patients* (4)-a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (i.e. Aspirin, Ibuprofen, Naproxen Sodium, etc.) is *4 per 10,000 patients* (5). The risk of serious complications or death from spine surgeries of the neck is *11.25 per 1000 patients* (5). As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and tests that will likely reduce the potential for stroke even more.

- This list of side-effects IS NOT EXHAUSTIVE and there could be other negative side-effects of various treatments rendered in this office.

X Initial: _____

I understand the risks and possible negative side effects of Chiropractic Care and other therapeutic modalities and treatments at Adjustments Chiropractic and Wellness that are involved in my treatment, and I have had the chance to ask questions of the doctor and staff regarding these procedures and make an informed decision in the treatment of my condition(s). I understand the risks associated with such treatments, but wish to be treated nevertheless for my condition(s). By initialing these sections and signing this statement I

authorize Dr. Donald L. Aivalotis, II and any or all members of the Adjustments Chiropractic and Wellness Staff to treat me using the methods designed by Dr. Donald L. Aivalotis, II /other doctors working for Adjustments Chiropractic and Wellness. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X Initial: _____

Chiropractic is a second largest system of health care delivery. As with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

ACCEPTANCE AS A PATIENT I understand and agree that **Dr. Donald L. Aivalotis, II** has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

X Initial: _____

ASSIGNMENT & RELEASE

RELEASE OF INFORMATION I authorize release of any and all medical/chiropractic information necessary to process this claim and request payment of insurance benefits to myself or to **Dr. Donald L. Aivalotis, II**.

PAYMENT AUTHORIZATION I authorize payment of any medical benefits from **Dr. Donald L. Aivalotis, II** to be paid directly to this chiropractic office for any services rendered to me.

STATEMENT OF AUTHORIZATION AND ASSIGNMENT In consideration of your undertaking to care for me, I agree to the following:

I. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or insurance adjuster in order to process any claim for reimbursement of charges incurred.

II. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

III. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name or as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies proceeds, whether it be all or part of which is due, I personally owe you.

PAYMENT IN FULL PER SERVICE I understand that I am responsible to pay for services rendered in full at the time of service or in advance of services. If payment is made in advance, and treatments are not rendered, a

refund will be provided for those services. Service charges may be in the form of co-payments, estimated coinsurance, deductible payments and/or cash based services.

If health insurance is being utilized, the service costs will be estimated based on verification of insurance benefits. The actual amount will be determined upon receipt of the explanation of insurance benefits. If additional monies are due, or if there is a credit, **Dr. Donald L. Aivalotis, II** will notify me to the balance of my account.

X _____ _____

Patient Name (PLEASE PRINT) Date

X _____ _____

Guardian's or Authorized Person's Name (PLEASE PRINT) Date

X _____ _____

Patient or Guardian's Signature Date

X _____ _____

Witness' Name (PLEASE PRINT) Date

X _____ _____

Witness' Signature Date