Informed Consent, Benefits, Risks and Treatment Options

I hereby request and consent to the performance of chiropractic care (spinal/extraspinal manipulation, manual therapy, lifestyle advice, etc.), including various physiotherapy therapies on me (or the patient for whom I am legally responsible) by licensed doctors and staff of Level Up Spine Care and Rehab, LLC who are now or in the future employed by Level Up Spine Care and Rehab, LLC. I have had an opportunity to discuss with the physician the nature and purpose of chiropractic care and other physical therapy modalities. I understand that prior to establishing a treatment plan the physician must perform an examination in order to determine the exact cause of the complaint. During this examination, the physician will perform some procedures intended to reproduce symptoms, which will allow for better understanding of the nature of my condition. There is a possibility that this exam may temporarily aggravate my symptoms. I also understand that results are not guaranteed. All patient care, including chiropractic care, has the potential for adverse effects. I understand that the risks associated with chiropractic care include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains; however these side effects are extremely rare. The most common side effect, following examination and treatment is muscle soreness. I do not expect the physician to be able to anticipate and explain all risks and complications, and I wish to rely upon the physician to exercise judgment during the course of treatment and/or procedure, based upon facts known to him/her. Some chiropractic manipulations may cause a “popping” sound which is related to a gas and fluid exchange between the joint surfaces. In addition to chiropractic care, there may be other treatment options for my condition. These may include : self administered care (ie over the counter analgesics, rest, ice, etc), medical care and prescription drugs, physical therapy, hospitalization and/or surgery. If I choose to use one of the aforementioned “other treatment” options, I am aware that there are risks of such options and I may want to discuss this with my primary care physician. I have read, or had read to me the above consent. I have had the opportunity to ask questions regarding its content and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treament for my present and any future conditon for which I seek treament.

Signature: _____ Date: _____