

Bromberg Chiropractic 201 Broadway Cambridge, MA

INFORMED CONSENT

CHIROPRACTIC

Chiropractic is system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptoms, disease or condition as a result of treatment in this office. We will always give you our best care and if results are not acceptable, we will recommend another provider whom we feel will assist your condition.

The most common type of adverse reaction to spinal manipulation is some degree of stiffness or soreness that may occur following the first few days of the initial treatment. This is equivalent to the soreness you would experience after initiating a new exercise program. If such soreness occurs after the first one or two treatments, it usually ceases soon. Should the soreness continue after this period, it is your duty to report it to us. Unless you communicate with us, we cannot properly treat you. Other more serious complications could include: fracture, disc injuries, dislocations or stroke, but it has been documented that such complications have only occurred in less than one in one million manipulations, At Bromberg Chiropractic, we employ simple clinical tests, which are designed to help identify those persons who may be susceptible to an injury.

CONSENT

By my signature below, I request and consent to the performance of chiropractic care including, but not limited to examinations, adjustments and supportive procedures, including various types of therapeutic modalities and exercise. Certain supportive modalities may be suspended in the following cases pacemaker, pregnancy, prosthesis cancer, metallic implant, etc. I consent that the licensed doctors of chiropractic associated with this office, who now or in the future treat me, will use their own well-educated judgment in caring for me. I have had the opportunity to discuss with the treating doctors of chiropractic and other office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand that in the practice of chiropractic as in the practice of medicine there are some risks. I do not expect the doctors to be able to anticipate and explain all risks and complications. I wish to rely on the doctors to exercise their judgment during the course of the procedures which the doctors feel at the time, based upon the known facts will perform accordingly in my best interest.

I intend this consent form to cover the entire course of treatment for my present reasons for care and for any future conditions for which I may seek treatment at this office. I have read or have had read to me this consent form. I have had an opportunity to ask questions about the information contained herein. By my signature below I understand and give permission for examinations and treatment at this office.

Print Patient's Name

Date Signed

Signature of Patient or Guardian

Relationship of Guardian/ Representative

Witness

Date Signed

Informing Doctor's Signature

Date Signed